

**A ‘St Giles Case’:  
Negotiating Mental Illness, Treatment and the Adverse  
Impact of Stigma in Suva, Fiji**

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## **APPENDIX 1: ETHICAL APPROVALS**

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## **CERTIFICATION**

This is to certify that the following thesis is my own work, except where acknowledgement has been made to the work or ideas of others. This thesis has not been submitted for a higher degree to any other university or institution.



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Natasha McDonald

## **ABSTRACT**

This thesis explores the role and impact of stigma on mentally ill individuals and the provision of mental health services within Fiji. Fiji is home to a multi-ethnic, multi-religious and multi-cultural population, which is currently undergoing rapid social change that is changing everyday life within Fiji. As a result there is a very diverse understanding around mental illness and how mentally ill individuals should be treated, therapeutically and socially. Therefore this thesis first explores the different etiologies of mental illness that exist within Fiji. I also investigate the relationship between understandings of mental illness and help-seeking behaviours, and the resulting treatment choices of Fijians in Suva. Finally, this thesis discusses how the subjectivity of the mentally ill individual is impacted in response to the intersubjective process of stigma, which is a prevalent issue within Fiji.

This research project was based in Suva, Fiji's capital city. A mixed method approach was utilized to meet research objectivities. Primary participant observation was engaged in over multiple sites: St Giles Psychiatric Hospital, Stress Management Ward, and the Community Rehabilitation Outreach Program. Additionally I attended outpatient clinics, home visits and mental health stakeholder meetings. In complement to participant observation, unstructured interviews (n=49) and focus groups (n=4) were conducted with in-patients, ex-patients, carers, mental health professionals and various NGO employees working in the area of mental health.

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## **GLOSSARY OF ACRONYMS**

CROP – Community Rehabilitation OutReach Program

CWM – Colonial War Memorial Hospital

GMH – Global Mental Health

mhGAP- Mental Health Gap Action Program

MHGAP-IG- Mental Health Gap Action Program –Intervention Guide

NCD – Non Communicable Disease

OT – Occupational Therapy

PSA- Psychiatric Survivors Association

SMW – Stress Management Ward

WHO- World Health Organisation

YC4MH – Youth Champs For Mental Health

## **PART 1: CONTEXTUALISING MENTAL ILLNESS IN FIJI**

### **THE WOMAN IN CHAINS**

In 2013 Fiji made international news headlines. A woman was found chained in a shed behind her family home. Her family explained she was possessed by a demon, who ‘has ruined her and is ruling her, it is commanding her’ (Dreaver 2013). Initially, in attempts to help her, the woman’s family had sought spiritual treatment through a healer. The healer however was unsuccessful. Concerned and scared, the family had not known what to do to help her. Finally they decided to confine her in a shed, which they believed was the safest option, as the woman was prone to violent outbursts, making her both dangerous to her family and at risk of harming herself. The woman was eventually found and hospitalized and a psychiatric assessment was performed diagnosing her with schizophrenia. As a result the local and national media implored families to seek help for their mentally ill relatives through established medical services, discouraging individuals from confining loved ones or seeking help from the likes of spiritual healers.

For me this story raised many questions. Specifically I wondered how diverse individuals recognise and treat what are commonly understood as mental illnesses in the developed, western world. Prompted by the news item mentioned above, with Suva, Fiji’s capital city, as my focus, my question narrowed. How do certain inhabitants within Suva understand mental illness? What role and consequent influence do individuals’ understandings of mental illness have on how they seek help for such illnesses?

Whilst there is little research around mental illness within Fiji, previous research has reported that mental illness within Fiji is heavily stigmatised (Chang 2011; Roberts 2007; Roberts, et al. 2007). My own research supported such accounts. However in response to such a concerning reality, my own project set out to understand how such negative understandings and attitudes around mental illness and mental health care were established and maintained.

Therein what follows in this thesis is a discussion of the relationship between models of illness and healing around mental illness, and of how individuals and carers negotiate the



terrain towards good health. In this thesis good mental health can be understood as a strong sense of wellbeing and self esteem. Models of illness and healing which attempt to alleviate suffering and achieve good mental health are adversely impacted by the influence of stigma within the country.

In order to investigate these questions this thesis has been divided into four parts. The first part will focus on providing context to mental illness and mental health care within Fiji by discussing current research in the area. Additionally this section will discuss the research methodology and justifications for this research project, outlining in greater detail the questions and focus of this thesis. The second and third part of this thesis will focus more heavily on my own fieldwork. The second part will explore the different models of illness and healing present in Fiji and discuss how individuals and carers use diverse forms of healing to make sense of mental illness. The third part of this thesis will then focus on the serious issue of stigma that is attached to the mentally ill and mental healthcare in Fiji, and the implications such negative attitudes have on various mental health stakeholders. Lastly the fourth part, the conclusion, will summarize the discussion held throughout this thesis and propose potential ways forward for mental health care and the reduction of stigma around mental illness.

## **A CALL TO ARMS: GLOBAL MENTAL HEALTH**

Three quarters of the world's global burden of mental illness is located in underdeveloped or developing countries (WHO 2010). However, this same population only has access to 20% of the world's mental health resources (Patel and Prince 2010). Mental health problems have become a global health concern, contributing to one of the ten leading causes of disability worldwide (Brundtland 2000). With mental health problems projected to increase, the reality of the gap between individuals suffering from mental illnesses and receiving appropriate treatment was a situation that could no longer be ignored by the world. To allow such inequality to exist would be seen as a moral failing (Kleinman 2009). Consequently a global

force focused on mental health was born from concern about this state of injustice (see Collins, et al. 2011).

The Global Mental Health (GMH) movement emerged, with the objective of closing the treatment gap, and the World Health Organization Mental Health Gap Action Program (mhGAP) was established to do so. The focus of this movement and program is the scaling up of care for mental, neurological and substance use (MNS) disorders, specially targeting non-developed and underdeveloped countries (Patel and Prince 2010). What is meant by the term ‘scaling up’ is the implementation of successfully tested health service interventions that will benefit larger populations and facilitate the establishment of long-term policies and programs (WHO 2008).

Fiji, considered a low middle-income country, is one of the 18 member countries committed to the Pacific Island Mental Health Network (PIMHnet), which is a sub-branch of the larger GMH initiative, focusing on addressing mental health issues for the Pacific region (WHO 2013). In order to reduce psychiatric morbidity within the country, Fiji is committed to de-institutionalising mental health services and the training of non-professionals in mental health concerns (WHO 2013). The World Health Organization (WHO) and the GMH movement have both been pivotal in re-establishing a focus around mental illness and mental health within Fiji.

Various training programs and interventions in mental health have been established with, or developed by, WHO; this was necessary due to the lack of established resources within Fiji. The University of the South Pacific currently offers both a degree in social work and psychology. However there are no accredited courses to allow for individuals to become qualified psychologists or psychiatrists, with individuals required to travel overseas to attain qualification in these areas. Only recently has a Graduate Diploma in Mental Health been introduced at Fiji National University (FNU): many of the practising physicians in psychiatry have completed this degree along with their medical degrees to work within the mental health field. Additionally, WHO Mental Health Gap Action Program Intervention Guide (mhGAP-

IG) has become an important tool in assessment, diagnosis and care in community outreach and rehabilitation programs within Fiji. GMH plays an influential role in the construction of knowledge around mental illness and health within Fiji, a fact to remember throughout this thesis.

## **CALL FOR CONCERN**

The GMH movement has not risen to prominence without critique. Questions have been raised about the implications of disseminating global psychiatric models of mental health care for local communities (Bemme and D'Souza N 2014). The assumption of psychiatric universalism in the GMH initiative has been critiqued for bordering on imperialistic—reinforcing Western ways of knowing as superior to indigenous models of illness and healing (Summerfield 2012).

The GMH movement suggests the ‘treatment gap’ and high rates of mental illness visible in developing countries can be related to ‘limited understanding of the brain and its molecular and cellular mechanisms’ within these countries (Collins, et al. 2011:27). This argument emphasizes the cause of mental illness as physiological, supporting a focus on psychopharmacological treatment. Critically, the importation of new psychiatric models of distress can be seen as opening local markets to ravenous ‘big pharma’ (Watters 2010). This critique focuses on the concern around the reconstruction of illness within local worlds through paradigms and models of dominant Western medicine, and draws one’s attention to look at power inequalities that are reflected in such exchange (Bemme and D'Souza N 2014).

More specifically focusing on the intentions of ‘closing the treatment gap’, Bartlett, et al. (2014) argue that the GMH initiative obscures and fails to engage with the local knowledge, actors and institutions who are already framing and managing mental health issues in current settings. This initiative fails to engage with and acknowledge expertise in non- Western traditions, ignoring the potential of a ‘mutually enriching dialogue’ where local healing traditions can widen perspectives of health care practices (Miller 2014). Instead the

focus on evidence- based practices intentionally or unintentionally favours scientific interventions due to their testability and reliability (Nastasi, et al. 2015).

## CONTEXTUALISING FIJI

The Republic of Fiji is located in the South Pacific Ocean, comprised of more than 300 islands and spanning over 18,000 square kilometres (Fiji Ministry of Health 2011). The population of Fiji is 881,065 and is largely concentrated on two islands Viti Levu and Vanua Levu (The World Bank 2013). Suva, the capital city can be found on the south east coast of Viti Levu. Fiji's population today is estimated to be comprised ethnically of 61% iTaukei and 32% Fijian Indian with the remaining percentage referred to as 'Other' (Fiji Bureau of Statistics 2014). Based on the 2007 national census 64% of the country belongs to a Christian faith, 27% are Hindu and 6.3% Muslim (ibid.). Fiji is home to a distinct multi-ethnic, multi-religious and multi-cultural society, which in turn can be understood to play a significant role in the wide understanding of mental illness and mental health within Suva.

Furthermore Fiji's history has been both turbulent and violent. Tomlinson (2004) explains the post-colonial history of the country has for many iTaukei individuals created as sense of social decline and threat. Prior to colonization by the British in 1874, Fiji's social life was 'hierarchal and based on the principal of patrilineal agnastic descent' (Lal 1992:4). The country was divided into confederacies, all with their own ruling chiefs. To say they were peaceful in their relations is false, with tribe warfare and political tensions between chiefs common (ibid.). Before colonization Fiji was known as the *Cannibal Isles* or *Cannibal Islands* a reference to the countries practice of cannibalism. Such an image saw Fiji seen as a fierce and violent nation, which kept many foreigners away.

However as Fiji was colonized the country underwent a vast social and political shift. With the colonial powers expressing an intention to promote Christianity, '*civilization*' and establish a stable government for Fiji's residents (Lal 1992:12). However colonial rule, which would last until 1970, resulted in various shifts and transformations in the country's identity,

population and politics. This was achieved through the rise of a ‘new religion’, which progressively dismantled and demonized previous spiritual practices and gods (Tomlinson 2004). Additionally the introduction of Indians through indenture, as well as the migration of Europeans and Chinese to Fiji changed the demography of a previously dominant indigenous population. Furthermore traditional hierarchies of chiefly systems were undergoing changes and coming in conflict with various colonial and missionary authorities.

The relationship between Fiji’s two largest ethnic groups deserves attention. iTaukei and Fijian Indian relations have been tense and have resulted in various conflicts within the country. Mishra (2014) explains at the heart of this are two competing imaginaries, one of the indigenous native and collective imagination and the other the Indian *vulagi* and individual imagination. The current day Fijian Indian population, as previously mentioned, is largely made up of descendants from Indian labourers brought to Fiji through indenture from 1879 to 1920. Once they fulfilled their indenture, many Indians became farmers, renting land from iTaukei landowners. iTaukei[s], which is translated into ‘people of the land’,<sup>1</sup> own a vast majority of the land through communal landholdings which have traditionally been leased to Fijian Indian farmers (ibid.).

Following decades saw the rise of tensions, where Fijian Indians were understood to be a growing dominant power encroaching on the Fijian way of life, a country where many iTaukei saw them as visitors. iTaukei individuals felt that Fijian Indians obstructed their own ability to obtain wealth and ‘hoarded’ resources, whilst simultaneously iTaukei values of communality were understood as incompetence in areas of business and their humility was perceived as passivity by Fijian Indian counterparts (Katz 1999).

The division of the two ethnic groups along with regional divisions has historically played a pivotal role in organizing Fijian society (Brison 2009). The tensions over disparate cultural values, ways of life and concerns over land resulted, and were expressed, in the 1987

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<sup>1</sup> Note this definition of iTaukei stays true to the definition provided in the reference cited. However iTaukei can also translate to the definition ‘owners of the land’. Definition around the direct translation is not unanimous. .

and 2000 coups. The coup in 1987 resulted in the migration of many Fijian Indians overseas, as many then felt uncomfortable remaining within Fiji (Williksen-Backker 1995).

Whilst ethnic tension continues to exist within current day Fiji, there is a much more complex history than can be expressed in writing here. It is important to also acknowledge that distinct cultural values and practices still play a part in organising and shaping social life, with the memory of a violent and conflictual history still present in the minds of many iTaukei and Fijian Indians alike (Katz 1999; Mishra 2014 & Williksen-Backker 1995).

I will note here for the sake of clarity, unless specified otherwise, when I use the term Fijian, I refer to both iTaukei and Fijian Indians. However this is a generalisation and does not reflect the very distinct histories, as well as social and cultural climates that define the every-day lives of these two groups (see Lal, 1992 for further reading on the 20<sup>th</sup> century history of Fiji). The use of Fijian to refer to these two groups reflects the current decisions by the Fijian government for the country's inhabitants to be referred to under a unified name.

Another prominent way life in Fiji is organized is through Christianity. Introduced by Methodist missionaries this 'new religion' now determines various facets of Fijian life at a personal and institutional level. This religion is seen largely as the religion of the iTaukei population (Tomlinson 2007), however in Suva many Fijian Indians also follow the Christian faith.

Additionally, globalisation has driven large-scale social change within Fiji (Foster, Kuruleca & Auzier 2007). The term globalisation can be defined as the increased global interconnectedness and the movement of resources and technologies across increasingly porous borders, establishing the complex interconnections and motilities that define modern life (Inda and Rosaldo 2002). This growing global economy has now given birth to tensions between clan and capitalist values that divide Pacific communities (Roberts 2007). Increasing wealth disparities, rural to urban migration, rapid population growth, limited employment opportunities, alcoholism, violence and a desire for capital accumulation, as well as changing social and cultural practices in areas of gender, chiefly hierarchies and village life are argued

as giving birth to distress, emotional disorder and negatively impacting mental wellbeing (Brison 2009; Forster, et al. 2007; Herr Harthorn 2005; Roberts 2007)

## **MENTAL ILLNES AND HEALTH IN FIJI**

In 2007, 10,777 individuals were registered as having been diagnosed with a mental illness (Sivakumaran, et al. 2015). Aside from this figure there is an absence of epidemiological data around mental illness within Fiji, which makes understanding the burden of psychiatric comorbidity difficult. Additionally this statistic likely underrepresents the burden of mental illness within the country, as there are various social, cultural and geographical barriers to individuals accessing mental health services to be diagnosed and registered with a mental illness.

Culturally there are various stigmatas that exist around being mentally ill which often encourage secrecy and deter seeking psychiatric care. Simultaneously, mental illness and/or madness is understood through various spiritual and cultural frameworks, which result in the pursuit of alternative treatments (Roberts, et al. 2007). These beliefs often explain mental illness/madness as the result of witchcraft, spirit possession or black magic. Geographically many Fijians, specifically on the outer islands cannot easily access mental health services, which are located on the central islands Viti Levu and Vanua Levu. In order to access these services many Fijians would have to travel by boat to the central islands, which requires certain finances and resources many Fijians do not have (Deva and D'Souza 2011). One psychiatric nurse, a young iTaukei man, explained to me that during his training he had been based on one of the outer islands, where there was no hospital and only one medical doctor. This doctor, he explained, would see everyone for any sort of ailment and if a patient was seriously ill the nearest hospital was only accessible by boat, a journey which often would take too long in cases of medical emergencies.

The largest change around mental health in Fiji in the last decades is the growing awareness around mental illness and mental health services. Recent efforts within Fiji have

concentrated on the promotion of awareness and combating the stigma and fear that surround mentally ill individuals and mental health services (Chang 2011). Non-government organisations such as Youth Champs for Mental Health (YC4MH) have run campaigns around stopping the silence around the stigma. YC4MH is a NGO comprised of young adults and youth advocating for the better treatment of individuals with mental illnesses. Their work involves active public campaigning, outreach programs to schools and peer counseling, where people can interact with others who face or have experienced mental illness in order to provide guidance and receive support.

Furthermore, this growing demand for the provision of mental health care has seen the spread of biomedical frameworks of mental illness to more rural areas of Fiji (Herr Harthorn 2005). This is visible in the government's outreach clinics which venture to rural areas within Fiji to promote awareness around the symptoms that can signal mental health issues. Mental health care has recently been decentralised from primary institutions and is provided through divisional hospital wards, clinics and community nursing (Deva and D'Souza 2011). The growth in resources and education around psychiatry has worked to change the conceptual construction of mental illness/madness and healing approaches found within the country.

Research is limited on the topic of mental health and illness within Fiji, particularly from a 'client-centred' perspective, where the mentally ill individual plays a central role in how the illness experience is understood. Previous research has focused on attitudes around mental health held by the public, nursing staff and mental health workers (Aghanwa 2004; Foster, et al. 2008; Foster, et al. 2009). Complementary works have also looked at the historical establishment of mental illness within Fiji through the establishment of The Fiji Lunatic Asylum during colonial rule (Leckie 2004; Leckie 2005; Leckie 2010) and historical accounts of idioms of distress such as *matiruku* and *drau ni kau* (Gluckman 1969; Price and Karim 1978).

Alternative works have focused on assessments of mental health services, suggesting a greater focus on issues around resource provision and increasing psycho-education to address



the continuing misconceptions around mental illness caused by traditional and spiritual explanations of disordered behaviour (Chang 2011; Deva 1999; Roberts 2007; Roberts, et al. 2007). Recent research into mental health services has provided insights into the various psycho-social issues facing mental health care help-seekers. Men report issues with substance abuse (kava, alcohol and marijuana), unstable employment, financial instability and grief (Sivakumaran, et al. 2015). Comparatively, woman expressed issues around family and relationship stressors, domestic violence, poverty, familial abandonment, fertility and general anxiety (ibid.).

### **STITCHING TOGETHER STIGMATA**

Cross-cultural research has found stigma to be a universal phenomenon (Link, et al. 2004). Stigma can be understood as a relationship between attribute—of the deeply discrediting kind—and stereotype (Goffman 1963). It is the process of stigma that infers that the stigmatised individual is somehow less human than ‘normal’ counterparts. This difference results in and reproduces various forms of discrimination, which have negative impacts on the stigmatised individual. Stigma within Fiji is a serious and detrimental issue, the discrimination and prejudice that mentally ill individuals are subject to are widely reported. The gravity of stigma, specifically stigma’s day-to-day impact on individuals is poorly explored, especially in the area of self-stigma.

Stigma within Fiji negatively impacts the mentally ill individual, their families, carers and medical professionals within the mental health system. Previous research (Chan and Mak 2014; Corrigan and Watson 2002; Golberstein, et al. 2008; Pescosolido, et al. 2008; Reavley and Jorm 2011; Vogel, et al. 2013) has shown that stigma can negatively impact help-seeking behaviour, treatment success, life-chances, self-esteem and the retention of hope within mentally ill individuals. Stigma is also understood to extend to family members who alongside the ill individual can be pushed to the fringes of society (Thirthalli and Kumar 2012; Yang, et al. 2007).

An anthropological approach sets out to engage with the social dimensions of lived social experience, exploring how individuals and groups engage with their local worlds. The anthropologist inquires and sets out to understand ‘what is at risk’ from the threat of stigma, whilst also trying to understand what the stigmatiser hopes to preserve of his or her own world through the practice of discrimination (Yang, et al. 2007). In such a task social psychologists have provided beneficial frameworks for analysis and understanding of the process of stigma.

Stigma is often enacted through *discrimination*, which is the behavioural product of *prejudice* which is the emotional response to a *stereotype* (Corrigan and Watson 2002:218). Stigma can be understood as being enacted on two levels, the first *public stigma* and the second *self-stigma*. Public stigma is often what we think of when discussing stigma, the negative attitudes, prejudices and acts of discrimination that are engaged in towards the stigmatised individual or group by the stigmatiser. Alternatively, self-stigma is the internalising of prejudices and stereotypes held about mentally ill individuals by the stigmatised individual into beliefs about oneself (Lucksted and Drapalski 2015:99). Whilst we acknowledge the structural and social barriers of public stigma, it is important to understand that self-stigma is also a serious threat to the ill individual and hampers self-recovery (Chan and Mak 2014).

Whilst social psychological research has provided important insights into the relational nature of stereotype, prejudice and discrimination, stigma cannot be reduced to this relationship for these models fail to acknowledge the greater complexities of stigma (Hinshaw 2007). In order to explore this more complex, everyday exchange of how stigma impacts day-to-day life and life chances for mental health stakeholders an anthropological approach is helpful. The vast multi-disciplinary research that exists around stigma has provided diverse categories of how one can approach such inquiry. Through using research from the realms of anthropology, sociology and social psychology we equip ourselves with a diverse and comprehensive body of knowledge to approach the study of stigma.

Yang, et al. (2007) offer the concept of moral experience as a lense to interpret and understand the behaviours of the stigmatiser and the stigmatised. This approach asks the question of ‘what is at stake’ and ‘what really matters?’ for the individual who is subject to stigma and the group or person engaged in the act of producing stigma. Exploring stigma from both positions goes further than discussing the negative impacts of stigma, additionally such investigation asks *how* stigma emerges and *why* individuals engage in such acts.

Yang, et al. (2007) highlight that the stigmatising of others can be seen as a pragmatic response to a perceived threat to one’s lifeworld, and a common response to the fear of the unknown. It is this element of stigma, the ability one has to justify acts of discrimination under the guise of self-preservation, that makes stigma, as the researchers explain, so resilient to being dismantled (ibid.). It is this exchange around stigma - the rationale engaged by the stigmatising group and the impact these attitudes and acts of prejudice have on the stigmatised individual- that will mark my later discussion of stigma.

By exploring stigma through the experience of my informants and through the everyday, personal level and attitudes of perceived stigma I set out to provide insight into what is at stake for mentally ill individuals. I discuss the impacts such an illness has on their lives and their future, as well as providing accounts of the lived experiences of mental illness and stigma and how this relationship reshapes individuals’ lives, often for the worse.

Exploring stigma within different contexts and from different situational standpoints highlights the diversity that defines such relationships. What became quickly clear in my own research and is supported by other researchers (Link and Phelan 2001) is that stigma exists in varying degrees and the threat of status loss or acts of discrimination are more or less pronounced for certain groups.

## ANTHROPOLOGY, MENTAL ILLNESS AND HEALTH

My research project is located in the sub-discipline of psychological anthropology therefore it is important to outline the specific approach this vein of anthropology has in approaching studies on mental illness and mental health. Firstly, psychological anthropology does not support investigations into mental illness that are constructed around a purely biological basis (Castillo 1998). Instead anthropologists are interested in the social, historical, political and cultural forces that determine mental illness. A psychological anthropology approach to mental illness and health can be expressed as influential anthropologist Byron Good (1997:231) understands it:

*“Mental health, mental illness, and mental health care remain social, psychological, and cultural to the core; they are powerfully influenced by macrosocial processes, shaped by local worlds of power and meaning, and constituted as distinctive cultural psychologies.”*

What is being explained here is that the immediate context plays an influential and determinative role in the manifestation, expression and recognition of mental distress. It is our sociocultural world which constructs the markers we use to define what is normal and abnormal, good and bad and to recognise when someone has deviated from societal expectations (O'Neill 1997). Therein an individual's society can be understood as a setting where individuals learn how to express distress and suffering in culturally salient ways, phenomena Nichter (2010) refers to as 'idioms of distress'. As mentioned before, an example of an idiom of distress within Fiji would be the historical account of *matiruku*. *Matiruku* was explained as the 'intervals of madness' an individual would experience exclusively during low tide, which would disappear by midday when the individual would return to normal (Price and Karim 1978).

With mental illness understood as involving such diversity, I suggest in order to acknowledge and unpack the socio-cultural matrix that defines mental illness that mental illness should be understood firstly as a form of socially deviant behaviour (Orley 1970). This perception of mental illness allows such behaviour to be understood as interactive (Jenkins

2004). This approach allows a focus on how the designation of difference to the mentally ill individual ultimately results in them being different (Castillo 1998). This approach provides a much more holistic approach to mental illness than accounts focused exclusively on biochemistry and psychopathology. Furthermore this approach allows the investigation of how understandings around mental illness directly impact how this illness is experienced for the individual, treatment sought and the resulting outcome (Luhmann 2000).

The existence of mental illness is an assumed universal truth within the ethos of the GMH initiative. However the existence of mental illness, the universality of its scope and its pathogenic roots have been hotly debated within the social sciences, primarily anthropology. Foucault (1988) famously rejected the notion of madness (which would come to be understood as mental illness in the 19<sup>th</sup> century) as a natural lived phenomenon experienced within the individual. Instead he argued madness was located in the social sphere, created through various cultural forces and social shifts, attitudes and beliefs, which in turn determined the experience of madness for the individual (ibid.).

Goddard (2011), in his research on being ‘out of place’ in Papua New Guinea, provides a strong critique to transcultural psychiatry. Goddard argues that whilst concepts of madness (*kekelepa*) did exist within PNG, to assume and apply a psychiatric framework and identify local expressions of madness as ‘mental illness’ obscures the reality of what one is bearing witness to within the context of a culture. Such typification obstructs local epistemologies and imposes one’s own ontological ways of being in the world onto others (ibid.).

However, other anthropologists have accepted mental illness as a universal reality, focusing instead on how mental illness is expressed, treated and accepted differently across cultures. Previously anthropologists (Devereux 1957; Wolf 1992) have discussed how various non-Western cultures have culturally salient, even prestigious, roles that mentally ill individuals can occupy, such as the role of shaman. These positions are explained as being

free of the stigma and allowing social inclusion into the society in a way that is lost in the Western world (Devereux 1957).

Alternatively other anthropologists have focused more on the nature of mental illness as shaped and bound by culture (McGruder 2004; Scheper-Hughes 2001). The focus of this vein of anthropology has been the inquiry into how the manifestations, expression, treatment and outcome of illness are shaped by various socio-political histories, cultural values, beliefs and modern day practices.

Finally, biomedicine and psychiatry as a sub-culture have been explored as cultural systems, bound and defined by certain practices, beliefs and ontological views. These investigations show how practitioners have distinct ways of perceiving illness and the ill individual (Kleinman 1988). These ways of understanding the ill individual and the illness experience can be disconnected and disparate from the ill individual's own understanding of their illness experience. More recently, specific to the area of psychiatry, focus has shifted into exploring the disconnects and contradictions of this medical discipline and how contrasting ideals of psychiatric care engage differently with individual suffering (Luhmann 2000).

This field of study around mental illness provides insight into the diversity of how such a concept is understood both cross-culturally and intra-culturally. What emerges is the reality that neither cultural expressions of mental illness are universal, nor are cultural understandings. As Aghanwa (2004) notes, the cultural diversity around attitudes to mental illness and treatment, specifically in the South Pacific region, require such topics to be studied across a wide range of cultures. Mental health policies are implemented and formed based on research often confined to Western settings, however Fiji is a multicultural and multi-racial society, whose demographic, socio-cultural and economic characteristics are distinct from those of western nations (ibid.). Therefore culturally specific research within Fiji is important towards improving mental health and better understanding of public and patient perspectives of mental illness and health.

## **METHODOLOGY**

### **THE RESEARCH QUESTION**

From December 2014 to April 2015 I was located in Fiji's capital city, Suva. I had long had an interest in the relationship between mental illness and culture. Primarily my interest lay in the saliency of the notion of mental illness, and how individuals within Suva engaged with and were affected by such a concept, which was reportedly so heavily stigmatized (Chang 2011; Roberts 2007; Roberts, et al. 2007). Additionally, whilst interested in the GMH movement's commitment to address mental health, I found myself in alignment with various concerns voiced around the limited attention paid to the local context. I was interested to see whether mental health programs adapted to local cultures and contexts, and how the decision - to do so or not to- impacted local people. In order to develop such understandings I deliberately assumed little about the nature of mental illness and health in Fiji. My intention was to be taught by my informants, invested in the area of mental health and/or experiencing mental illness, how the landscape of mental health and illness could be understood. To provide structure to such an inquiry I broke my research questions down as follows:

1. What are the etiological beliefs around mental illness / madness within Suva's diverse population?
2. How do individuals and their carers, based on their understandings of mental illness/ madness, seek and engage treatment?
3. How are mentally ill / mad individuals viewed and treated by society?

### **CONTEXTS**

My research within Fiji was conducted through various mental health institutions and services provided by the Fiji Ministry of Health. These facilities were largely interconnected with various overlaps at times in psychiatric personnel. All these facilities were found throughout the greater Suva area, which was the geographical scope within which my research took

place. I have outlined the role of each of the institutions or services below to provide an overview of the various contexts in which research was undertaken:

### **St Giles Psychiatric Hospital**

St Giles Psychiatric Hospital, referred to commonly as ‘St Giles’, is the sole psychiatric institution within Fiji. Located on the outskirts of Suva city, the hospital is situated in close proximity to both the Suva prison and various cemeteries. The hospital has a bed capacity of 190 and is divided into two wards: chronic and acute. Men and women are segregated internally. The facility offers inpatient services, outpatient clinics, counselling, occupational therapy, forensic services and also is a teaching hospital for both doctors and nurses from the Fiji School of Medicine and Fiji School of Nursing. The hospital is the primary provider of mental health care within Fiji. My own research was primarily conducted in the occupational therapy centre and on the woman’s chronic ward.

### **Stress Management Ward (SMW)**

The SMW is an eight-bed ward located within the Colonial War Memorial Hospital (CWM), Suva’s regional hospital. The SMW is targeted at providing care for individuals who suffer from stress or mild mood disorders. The ward was established in 2013 and takes both male and female patients. Additional to providing inpatient care the ward also offers occupational therapy to patients.

### **Community Psychiatric Nursing (CPN) Clinics and Home-Visits**

The CPN team operates out of Namosi house and consists of a team of four mental health trained nurses, two medical orderlies and a mental health trained physician. One nurse and a medical orderly conduct the Community Rehabilitation Out Reach Program (CROP), whilst the remaining team conduct clinic visits and home visits throughout the wider Suva area. During my research I took part in the two mental health clinics which ran weekly in the



Nausori and Valelevu area. These clinics were also often accompanied by home visits to individuals within those areas, who were understood to have issues reaching clinics or lived in more isolated areas, often shantytowns. Additionally, I also accompanied health workers' visits made to St Vincent House, a home for individuals who suffered from disabilities.

### **Community Rehabilitation Out Reach Program (CROP)**

CROP is a sub-branch of CPN and is located in an old building which was called the 'old Fiji Medicine building', which was a street down from the CWM hospital. The rehabilitation program is the only one of its kind within Suva and is designed to provide rehabilitation services for ex-inpatients of St Giles and CWM or clinic outpatients. The program is run by a medical orderly and a psychiatric nurse with the support of volunteers from YC4MH. Additionally CROP receives the support of public volunteers; often they are carers or ex-carers of a mentally ill individual. Admission to the program requires a doctor's referral.

These four sites were the primary sites of my research and are all interconnected, as I often shifted over multiple sites throughout the day. Clinics, for example, often ran until midday and in the afternoon I would venture over to CROP or either of the hospitals. Staff would perform duties at various sites depending on necessity and resources; particularly the psychiatrists (who are limited) who would move between sites to provide services. Patients themselves also moved between sites, often depending on their status as inpatient or outpatient. An individual may appear in a clinic to soon be readmitted to hospital, or he/she may leave hospital and be referred to join CROP. The multiple settings provided insight into how mental health services were provided in different environments: clinical, community and rehabilitative settings. A multiple site study also provided insight into the various ways individuals negotiated illness and understood themselves in different therapeutic settings.

## RESEARCH METHODS

In order to meet the objectives of my research I utilised a mixed method approach. Primarily, I engaged in and prioritised participant observation, which is in alignment with the traditional convention of anthropological research. Ethnographic research favours participant observation, the practice of the researcher immersing herself into the context of her study through becoming a part of a social group and engaging in lived day-to-day activities of her informants (Byrne 2001). I engaged in participant observation over all of the four previously mentioned sites. Due to the vulnerable population (mentally ill individuals) I had chosen to focus on, I believed building bonds of trust and facilitating familiarity with my informants was essential.

My introduction to patients, regardless of whether they were attending outpatient clinics, were ex-patients or inpatients at hospital, were always provided through medical staff with whom the patients were familiar. After gaining an introduction to a potential informant I would always explain the nature of my study, asking again if the informant was interested in partaking in my study. I was clear that informants were free to remove themselves from the study at any stage of the project and that all information provided by them could be erased. Additionally, I explained to informants that they were allowed to determine what pieces of information they shared with me could be used in my project, and what exchanges I could tape-record.

Furthermore, I offered participants the option to read anything I wrote exclusively about them. This decision was in order to ensure that they were comfortable with the type of work I was undertaking and were able to see what was being said about them. These decisions were made due to the vulnerability of the group I worked with. I wanted to ensure in whatever way possible that informants did not feel coerced and did feel in control of how they participated in my research. Most importantly I wanted to build trust and establish a relationship where individuals felt comfortable sharing intimate details about their illness experiences.

Consent was an important focus of my project. I was worried about coercion and did not

wish to exploit anyone due to various power inequalities possible in researcher/informant relationships. My main concern had been that patients and nursing staff would be forced to talk to me. However, I found that many individuals were comfortable saying no if they did not wish to partake in my research project. If I ever encountered potential informants who hesitated I encouraged them to think about their decisions and explained I would return to them to ask again at a later date. Furthermore I often found that mentally ill individuals and carers were eager to share their stories and experiences. For some it was not their first time being interviewed about their work or illness experiences and they were eager to participate, explaining they either loved their work or sharing their story. In instances of interviews, focus group, and environments where long-term participation occurred, as well as when a tape-recorder was used I ensured written consent was obtained from all participants. Otherwise in passing conversation I would make sure I had verbal consent from all participants (please see Appendix 1 and 2 for a copy of the consent form and information sheet).

In complement to participant observation I also conducted unstructured interviews (n=49) and unstructured focus groups (n=4). My interviews were conducted with a broad range of informants, primarily mentally ill individuals who were both inpatients and outpatients, mental health trained professionals and carers. In addition interviews were also conducted with non-specialist nurses, government officials, NGO's members and advocates invested in mental health. I conducted interviews in various settings; from clinics, public corners, patient's living rooms, communal therapy rooms, hospital wards and in government offices. I found that many individuals were not specific on the environment of interviews, as long as it was quiet enough the informant and I to speak to one another clearly. I would always use my tape recorder if given the opportunity and in addition took notes. However I preferred the tape recorder and often took notes after conversations as I liked to focus my attention on the individual I was interviewing. Informants were comfortable with the tape recorder and I often placed it on a table out of the way, in order to make such talks more informal. No problems arose with the tape recorder aside from one focus group where one

participant asked that it not be used. In this instance I asked if she would mind if I took notes of the focus group and she said that she was happy for me to do so.

As mentioned previously, aside from interviews I also conducted focus groups, with the primary intention of understanding how individuals negotiated mental illness and health in group discussion and settings. Additionally this approach allows the researcher to observe a 'natural language discourse' through observing how individuals interact with one another and discuss proposed target topics. In this way, the researcher can learn idiomatic expressions, common terminologies and communication patterns (Schensul 1999). My focus groups were conducted with carers, outpatients and mental health professionals. The information collected from this setting further provided analysis for how individuals respond to one another's ideas and how they collaboratively engage in making meaning out of various experiences and concepts. Focus groups I found were not as successful as informal discussions, specifically amongst mentally ill patients. I often felt it was because a forced communal setting seemed overly formal. This resulted in my decision not to conduct as many as I had originally intended to.

Through using this mixed methods approach, I hoped to gain an understanding of how individuals act and negotiate illness and treatment within various settings. Furthermore I was interested in engaging mentally ill individuals, carers and mental health professionals in reflections about their own understandings around mental illness, and their motives and hopes for treatment. Due to the personal nature and the vulnerable position of my informants I assured my informants that pseudonyms would be used at all times. Additionally, I will note at times descriptions are deliberately vague about where someone works or where I have met them. This is due to the small network of mental health stakeholders and workers and informants' wishes to not be too noticeable to others. Alternatively, some informants have assured me that they would prefer for their names to be used. In these situations, I have conceded to their choice. Please note for all inpatients pseudonyms have been used, as this is to ensure confidentiality. Furthermore, in instances where informants have expressed they

‘didn’t mind’ if a pseudonym be used or not, I have chosen to use a pseudonym. One thing I have learnt during my fieldwork is that informants, specifically individuals who are dealing with mental illness, will struggle with their openness on such a topic. At times informants are willing and eager to discuss their experiences, whilst on other occasions their experiences are a source of deep hurt, grief or embarrassment. Due to the ambiguity of how numerous informants felt about their illness and diagnosis, I have felt it is best to err on the side of caution should there ever come a time where an informant may regret the use of their real name in this thesis. The use of a pseudonym will be indicated in the footnotes. The research methods have received ethical approval from both Macquarie University Human Research Ethics Committee (ref: 5201400985) and the Fiji National Research Ethics Review Committee (ref: 2014.123.C.D).

## **JUSTIFICATIONS FOR AN ANTHROPOLOGICAL APPROACH**

These various methodological approaches have been chosen due to the richly detailed accounts they produce of individuals’ everyday lives. They provide strong anecdotal data into the way mental illness is constructed individually and through various social relationships and forces. It is through examining and observing informants’ day-to-day practices and happenings that ‘what matters most’ or ‘is at stake’ for them becomes visible (Kleinman 1988). This understanding provides invaluable insight into what the cost of illness is to the individual, their family and the broader community. This sheds insight, in turn, into how these groups construct meaning and understanding around mental illness and set out to treat it. Additionally it is through engaging with the emotions evoked through fieldwork and in the field that one can add a richness and awareness to the life worlds the researcher is invited into (Davies 2010).

Ram (2015:30) explains ‘ethnographic practice depends on assuming the capacity to enlarge our own experience by incorporating perspectives of others’. The experience of mental illness is not isolated to the individual sufferer. A much more complex relationship of

social exchange, knowledge and lived experience determines what mental illness is, how help should be sought and treatment undertaken.

## **PART 2: MENTAL ILLNESS AND HEALING IN FIJI**

### **MENTAL ILLNESS / MADNESS**

When discussing mental illness and madness within Fiji it is important to understand there is both an overlap and distinction around both terms. For the sake of clarity throughout the rest of my thesis I will address this issue of definition first. Often the two terms ‘mental illness’ and ‘madness’ are used interchangeably to refer to someone who is mentally ill, or displays unusual and bizarre behaviour. Common words aside from ‘mad’ used to describe mental illness are *lialia* (Fijian (f): crazy/mad/stupid), *pagala* (Fijian-Indian (f-i): crazy/mad) or ‘St Giles’, which refers to the sole psychiatric hospital within Fiji, located in Suva.

However being ‘mad’, *lialia* and *pagala* can also be a term used to describe someone who has become ill because of various spiritual and traditional causes, such as possession or black magic. More common though, as I witnessed during my fieldwork, was how these terms were used as insults and slurs, at times directed at mentally ill individuals or oddly behaved people on the street and other times as a cruel jest said to a friend.

Using mental illness synonymously for madness is misleading and ignores the ontological beliefs of my informants and how they understand mental illness to be caused. In order to try and highlight the diversity present around understandings of mental illness and yet not obscure accounts of madness, I will at times use ‘mental illness \ madness’ to indicate when there is an overlap or fusion around understandings of disordered behaviour.

### **THE CURRENT CONTEXT OF ILLNESS AND HEALING IN FIJI**

How mental illness within Fiji is understood is diverse and established through various explanatory models. These diverse models of illness play an influential role in help-seeking behaviour. How illness is constructed and treatment is determined is deeply bound within the culture. All societies search for meaning behind illness and suffering, establishing culturally specialised bodies of knowledge, with distinct healers and therapeutic models targeted at addressing illness and providing care (Good, et al. 2010). Furthermore cultural and social

contexts play an influential role in sanctioning or promoting various illness explanations and treatment.

As mentioned previously, misconceptions and stigma around mental illness are obstructive to the provision and acceptance of mental health care services. Mentally ill individuals and their carers turn to alternative treatments, which often results in the discontinuation of mental health clinic and hospital visits, as well as abandoning medication. The alternative treatments which patients often seek are not limited to but include the use of various substance abuse drugs, traditional and spiritual healers –both of which are referred to as witchdoctors by informants- or practices such as resting and discontinuing studies in order to minimise stress. These alternative treatments are a source of frustration and exasperation for mental health professionals in both clinics and hospitals who will often readmit patients after months, even years of not seeing them. These same patients who reappear, often return with worsened symptoms and deteriorated health, making caring for them more problematic and often with a worsened baseline for practitioners to endeavour to return them to.

Within Fiji there is a visible diversity and at times tension around understanding and treatment practice in relation to mental illness. This tension I believe reflects a society in flux, where previous traditional understandings of madness are becoming what Watters (2010) describes as ‘colonised’ under a new biomedical paradigm. Traditional models of illness within Fiji have previously identified the cause of illness within socio-moral and cosmological frameworks, establishing illness as a deeply communal experience (Becker 1995). These models are distinct from the biomedical model of mental illness, which acknowledges social factors yet emphasizes biogenetic causes as the basis of illness, creating a deeply individual illness experience (Hahn and Kleinman 1983).

My research was located within various mental health settings, where there was a strong clinical psychiatric focus. However the expression of alternative beliefs around illness were commonly expressed, often by ill individuals and their carers who also admitted to pursuing alternative medicines in tandem with receiving psychiatric care.



This phenomenon, of how individuals negotiate multiple models of illness and healing around mental illness, and the question of *why* is the focus of the first part of my thesis. What I will set out to do in the next two sections is firstly discuss how various models of illness co-exist and at times compete within Fiji, exploring the significance around such phenomena. Secondly I look at the continued theme of medical pluralism in treatment amongst patients and carers, focusing on how various treatments can be understood to have distinct implications on the personhood of both patients and their carers.

## **ILLNESS AND DISEASE**

A common distinction made when comparing traditional models of illness to biomedical models is how the two models construct sickness in very different ways. Traditional models, an encompassing term I have used here which refers also to spiritual and cultural explanations, focuses on ‘illness’ whilst the biomedical model focuses on ‘disease’. *Disease* is a physiological malfunction which impairs the individual, whereas *illness* is the subjective experience of symptoms and suffering which in turn motivate help-seeking behaviour (Wiley and Allen 2008: 11). *Illness* is the shaping of disease into experience and emerges from cultural, social and personal reactions to disease (Kleinman 1980). This construction of illness occurs as a primary function within health care systems and is an intrinsic and initial stage of healing which brings meaning to suffering (ibid.).

## **THE CAUSE OF ILLNESS: BIOCHEMISTRY OR BLACK MAGIC?**

A common misconception during my research was that I was an authority figure on biomedical explanations of mental illness. The assumption by many ill individuals, carers and even at times nurses, was that I had the answers to what biological and physiological interactions occurred to make one ill. More importantly people hoped I had the answer to whether mental illness was permanent or temporary. These were misapprehensions that I was

quick to rectify and often used as an opening to inquire into what mental illness meant to my informants.

These exchanges provided me with valuable insights into—with the exceptions of psychiatrists and long serving psychiatric nursing staff—the marked confusion that existed around psychological explanations of mental illness. Alternatively, when I spoke with patients and carers about how illness was caused through spiritual and traditional explanations I was provided with confident answers.

This is an important distinction to note as this reflects the longstanding presence of traditional models of illness in ordering Fijian life. Simultaneously such exchanges reveal, unlike Western counterparts (Kleinman 1988; Luhmann 2000), that science and medicine have a limited influencing presence—even within the city—on everyday life in Fiji. The retention of traditional models to explain illness is reflective of the way these models engage in socio-moral worlds, which is important to how individuals continue to understand, negotiate and experience mental illness within Fiji.

Additionally explanations around the cause of illness through traditional illness models provide insight into various personal, social and cultural tensions that shape everyday life for many informants. On occasions traditional and biomedical explanations would be conflated by individuals to create personal meanings of illness and make sense of suffering in an environment where explanations of illness are diverse. I would like to address what I mean by both of these comments through a comparison of the two models in the following sections.

## **THE BIOMEDICAL MODEL OF ILLNESS**

Despite the clinical orientation of mental health services it was rare to hear individuals attribute their illness to purely genetic causes. Instead social stressors, such as relationship breakdowns, work and education were regularly described as the reason for the onset of mental illness. In addition to these reasons studies have also identified rural-urban migration,

substance abuse and poverty as influential factors in the onset of mental distress (Aghanwa 2004; Sivakumaran, et al. 2015). Psychiatric diagnoses were often accepted only to be re-interpreted and re-constructed as being caused through means of witchcraft and black magic. This phenomenon was commonplace within clinic settings and during home visits, yet largely absent within the hospital setting. It is important to understand that by routeing the cause of illness through a spiritual or magical model an individual can largely ensure continued social acceptance in ways that being ‘mentally ill’ does not allow.

Informants often also interpreted the implications of mental illness to mean their brain was irreversibly damaged. I was told by one CROP attendee Mary<sup>2</sup>, *‘I am sick because my brain is broken.’* This ‘default’ in the brain was repeated to me again by an inpatient, who whilst tapping her head furiously stated *‘there is a bacteria eating my brain’*; she explained stress from her everyday had started this processes. Backe (2013) rightly speculated education around mental illness and mental health is limited. Biological and genetics concepts around illness are not widely spread within Fiji, specifically in relation to psychiatric disorders. Mental-health professionals often explained it was during medical school and nursing school they were first exposed to and educated about mental illness.

This limited knowledge around mental illness is arguably reflective of limited education (ibid.) in the areas of science, not just mental illness. Although many individuals do attend primary schooling, the numbers drop to nearly half when viewing records for the intake for secondary schools (Fiji Bureau of Statistics 2014). It is often in secondary school people spoke of taking ‘sciences’ which established understandings around biology.

As a result the first time individuals hear explanations of illness caused by a ‘chemical imbalance’ is when they first receive their diagnoses during their first admission to hospital or visit to a clinic. I argue that explanations and diagnoses are reconstructed and reintegrated into pre-established notions of illness, which reconnect the solitary and individual nature of psychiatric diagnosis with the sufferer’s social world. This process provides control and

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<sup>2</sup> Please note a pseudonym has been used here.

familiarity in the turbulent and confusing processes that constitute mental illness and seeking treatment.

## **THE TRADITIONAL MODEL OF ILLNESS**

As previously stated, illness explained through traditional and spiritual frameworks has a long history in Fijian society. Madness is described as the result of transgressing various taboos, breaching familial and kinship obligations, black magic, curses and spirits. Spiritual and traditional systems are ones I have brought together as they were always discussed during fieldwork as overlapping. The causes of madness due to moral and social failings or the failure to repent for wrong doings were also understood as the result of traditional and spiritual forces. Traditional and spiritual explanations for madness were inseparable from the social world and tied to specific cosmological and ontological beliefs.

The most commonly cited reason for causing mental illness / madness within various settings was black magic. Black magic within Fiji was often explained as being pursued out of jealousy, hate or revenge (Flint 2015; Katz 1999). Additionally, if one's ancestors practised black magic and did not repent for such acts their descendants were believed to become sick for their wrongdoings (Becker 1995). As a woman explained to me in clinic one morning, as she sat waiting for the doctor:

*'If your forefathers have done something wrong, if they have practised witchcraft and they have never apologized or asked for forgiveness the curse will go on. Their descendants will never be successful, they will never be able to keep good jobs or excel in school. They will become sick or go mad.'*

Additionally it was possible for someone to have resented their forefathers and to have cursed them, only for illness to manifest in the children or their offspring. It is in these exchanges and manifestations of madness that family members are often identified as having played a role in the cause of illness, which opens the whole family unit to social speculation and potential scorn.

Black magic is not casually discussed in detail; individuals are often reluctant to speak about or are unsure of the exact logistics of how curses are performed or certain rituals undertaken. This is reflected in the way such practices are seen as ‘devil worship’ and often villainised within Fiji, specifically by Christianity (Katz 1999). It is through explanations of why black magic is used against someone that social, familial and cultural tensions are often expressed. What is targeted through black magic can be understood as attacking what is ‘most at stake’ (Kleinman 1998) to the threatened individual. What is targeted through black magic provides insight to what is important to families and reveals the aspirations and dreams of the individual, showing components of what he or she sees themselves needing to living a moral life (Kleinman 2006). Often what is targeted through these means are things understood to be scarce or seen as desirable within Fiji; resources such as education and health or opportunities for wealth, marriage and employment. Furthermore the existence of black magic is widely accepted and the threat of such harm still continues to guide behaviour and shape social life today for many Fijians.

Separate from black magic, yet also commonly cited as the cause of madness are curses. Curses can be performed in various ways through the use of kava, under a full moon or through the consultation of a witchdoctor. Ratu<sup>3</sup>, an iTaukei nurse who worked on one of the psychiatric wards explained to me, during a full moon an individual can dance nakedly at the stroke of midnight. Ratu had been raised in a village within Burebasaga confederacy, often returning like many indigenous Fijians for the weekend or festive occasions. For him and his village many of these ‘things’ were still very important. Ratu explained to me in order to curse someone, the curser must have something belonging to the individual being cursed, for example a strand of hair or an item of clothing. It is to be placed in the middle of the circle around which the individual dances, speaking a ‘*specific language only he knows*’. Once the item belonging to the person has been cursed it must be returned to them in order for the curse to work. This is why one should never leave one’s clothes on the line after nightfall; Ratu

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<sup>3</sup> Please note a pseudonym has been used here.

warned me: *'You never know what people are capable of doing.'* Despite being a passionate mental health nurse Ratu himself still believed deeply in various traditional practices and in the threat of witchcraft.

Ratu was not alone in such beliefs. In fact his comments were far from uncommon, many iTaukei nurses described to me accounts of madness, which could be caused by breaching various traditional taboos, or were the result of *vanua* (the land) or the *Vu* (Fijian gods) (for more details of traditional accounts see Gluckman 1969; Katz 1999; Tomlinson 2007; Tomlinson 2004).

Whilst traditional accounts of taboo were provided to me by iTaukei informants, beliefs about possession, curses and black magic were not exclusive to any ethnic group. Many informants explained their mental illness/madness as being the result of cursed objects being thrown over into their compounds or onto their properties. These items could be sourced many explained from 'witchdoctors' or made if one had the knowledge to create them. Witchdoctors were also used to call spirits and demons who could do harm and possess an individual. The motivation for engaging in such practice was jealousy, revenge or malice. Ratu further explained to me:

*'When someone is excelling in the world—in the academic world, other groups, other families might not like this one to go really up and they will do witchcraft and do things to get that person down. To weaken them from achieving their dreams, otherwise that person might be famous one day.'*

This theme was continuous and was most prominently cited as the cause for illness in individuals who had become ill during their late adolescence or early adulthood. As a mother explained to me about her daughter, *'She was getting good grades and people became jealous so they used magic on her.'* Jealousy visibly stemmed from various inequalities that define social hierarchy within Fiji. Wealth disparities have increased and education opportunities are unequal. Many individuals within Suva aspire to wealth, skilled migration and a better life yet few are in positions to achieve such things.

Additionally globalization has exposed inhabitants to various goods, experiences and possibilities in life yet there is a marked inequality on who can access the benefits of such changes (Inda and Rosaldo 2002). Furthermore modernisation is redefining village life, dismantling gender and chiefly hierarchies and forcing migration (Becker 1995; Herr Harthorn 2005; Roberts 2007). Such hopelessness, defeat and crisis in identity provide fertile ground for mental and emotional distress.

## **COLLABORATING MODELS**

What causes illness? In the face of sickness, this question becomes one of the most important that can be asked. In the turmoil of the unknown, explanations of causation provide direction and meaning. Such classification is an initial step in the healing process, establishing a trajectory for the course of the illness experience and ultimately leading to the ideal outcome, namely healing (Kleinman 1980). The establishment of illness identifies valid treatment options, casts the illness into various historical, political and socio-moral frameworks. Additionally establishing illness determines how the ill individual can negotiate his or her identity and in turn how society can understand them. So how is mental illness / madness understood in Fiji today, with such diverse models of illness used to explain such phenomena?

Schwartz (1969) argues 'native' and European healing systems co-exist, working to complement and at times compete with each other. My own time in Fiji supports such a claim, as I commonly found causal explanations of mental illness were not seen as mutually exclusive for many ill individuals. However, the tension and competition between explanations around illness was visible amongst various healers and medical professionals who worked to legitimate their models of treatment and consequently the supporting explanation of illness. For individuals, different explanations around the cause of mental illness are conflated in order to create a version of what causes mental illness/madness that meets personal, cultural and social needs.

As previously stated biomedical explanations promote a disease entity, which is isolative and disengages the individual from the broader social world within which that individual resides. Biomedical models of illness then show themselves as being distinct from traditional models of illness which are deeply embedded in social life and communal narratives of illness. Therefore by engaging with various explanatory models of illness, individuals are able to retain important therapeutic facets of illness that order and negotiate social life.

It is not uncommon for madness/mental illness to be viewed as the result of a biochemical imbalance that is *caused* by black magic. Therefore the overlapping uses of the witchdoctor, psychiatrist and priest are rational and valid avenues of treatment. These personal explanations are not seen as inconsistent or competing, but are sought in order to maximise the opportunities of healing and create hope.

## **TREATMENT TRAJECTORIES**

Finkler (1994) argues pragmatism prevails above all else in an individual's pursuit of treatment. The success of treatment outweighs distinguishing between the epistemological differences in various models of healing such as biomedicine, spiritual and traditional healing (ibid.). Schwartz (1969) additionally argues that individuals often have a hierarchy of resorts when pursuing healing; what he means by this is that individuals explore multiple treatment avenues, which they often organize hierarchically based on preference. Therefore individuals will engage with various treatments based on desirability, moving to the less preferred treatment choices in the face of failed healing, a process that continues until a desired outcome is found (Schwartz 1969).

Within Fiji practicality does prevail with the ideal outcome of healing being the return of good health for the ill individual. Critically, I would argue that treatment is not pursued in a strictly hierarchical manner within Fiji. Instead individuals often engage in various forms of treatment simultaneously. Despite this general tendency, it was apparent for many that St



Giles Hospital was the choice of desperation. The hospital was often a place people turned to when they had exhausted all other options; it was well understood and described as a 'place of last resort'. Furthermore to say ill individuals and their carers did not distinguish between the various epistemological differences attached to treatment options would be incorrect. It is the very fact of the different implications of treatment that becomes a great source of struggle for families and individuals, who understand that various treatments have life changing consequences for the future of loved ones and their acceptance and place within society.

As mentioned before, stigma around mental illness is a pressing issue and St Giles Hospital, the primary provider of mental health care is viewed with much apprehension. Often an admission to St Giles isolates an individual away from their community and society as a whole, whilst the process of hospitalisation confirms him or her as 'broken'. Alternatively traditional and spiritual treatments are largely communal and ensure the continued interaction and consequent reestablishment of the ill individual into society (Katz 1999). Furthermore hospitalisation does not only mark someone as broken, it establishes them as permanently and irreversibly damaged. Alternatively spiritual treatments often construct expressions of madness as temporal, an illness which will eventually disappear once the socio-moral cause of it is resolved (Becker 1995). With this in mind I would like to discuss how various types of treatment are undertaken and how they are negotiated and impact on personhood.

## **BIOMEDICAL MODELS OF TREATMENT**

Biomedicine has been critiqued for dehumanising the sick individual, through a failure to focus on an individual's suffering and instead focusing on the disease entity (Good 1994). This orientation on disease is problematic within the area of mental illness, as no exact disease entity has been found to explain the cause of mental illness (Waxler 1977). The administration of psychiatric medication then is largely based on symptom management (Castillo 1998).

The provision of psychiatric care within St Giles Hospital has a strong clinical orientation. Focus is centred on symptom recognition, diagnosis and treatment through medication. As one doctor passionately explained in rounds one morning, *‘we fix them (patients) to make the acceptable.’* His ethic centred on the belief that with the right medication an individual’s symptoms would dissipate and they would be able to return home. Clinics are similarly orientated, designed largely to ensure patients are maintaining a good baseline and to renew scripts. Consults are often quick, a necessity to see the consistently long list of patients who come.

It is worth recognizing that the social stressors causing mental illness are greatly emphasized upon admission to hospital. However this concentration on social forces which are understood to be an influential factor in admission, fails to make its way into therapy to be discussed, with medication being regimentally provided instead. This practice and arguable *overemphasis* on medication was a source of strain amongst clinical staff that had differing views on such approaches. As a disheartened psychiatrist told me:

*‘They overmedicate patients. There’s nothing left of them. It’s a regression it feels, back to treatment in the 1990s. Patients are discharged when symptoms dissipate but the social stressors are not addressed. The psychosocial stressors are acknowledged and staff are aware of them, yet they are not considered serious issues that require addressing before patients are discharged.’*

This psychiatrist’s account echoes the divide that Luhrmann (2000) argues is visible in American psychiatry, the competing of two different approaches around patient care. The psychodynamic approach which identifies the root of distress in one’s social history versus the psychopharmacological approach. The psychopharmacological approach is largely the therapeutic approach that I have explained occurs within Fiji, whereby one focuses on disease and accordingly provides treatment through pharmacological intervention.

In Fiji there is a deficit and seeming disinterest in therapy-based treatment, as a counselor explained to me about many of the inpatients, *‘people only come to see me once*

*they are made to, people are not used to talking about their problems or they do not want to.'*

Some informants describe this hesitation or refusal to talk about oneself as a 'culture of silence' where all Fijians practised an attitude of perseverance and stoicism in the face of hardship. Whilst this 'culture' was visible, there was little self-reflexivity about such behaviour and many people said they were aware of behaving so, but they did not know why.

I often found informants expressed a positive response about receiving therapy or from sharing their story. Many felt understood and finally heard as a result, describing they felt '*cared about*' and '*loved*' from such exchanges. However within St Giles currently there is only one permanent counselor and SMW receives counseling support from a NGO called Empower Pacific. There are no established psychologists within both hospitals and the shortage of psychiatrists make the regular provision of psychotherapy difficult. The limited resources in providing psychotherapy and adequately trained counseling support create an environment where the use of medication as the dominant medium of treatment is easily justified.

## **WHY DO I HAVE TO TAKE THE MEDICINE?**

Despite the dominance of psychotropic drugs as a treatment form in Fiji, it is not without problems. Previous research (Aghanwa 2004) established many individuals described taking medication as one of their greatest concerns about having and treating a mental illness. During my own fieldwork medication was a visible source of contention for patients, families and physicians. Common issues centred on the patient's non-adherence to medication and the growing critique around over-medicating patients, which I previously introduced.

Patients were often unsettled by the notion of taking medication indefinitely, as doctors are unable to provide clear indicators of how long medication will be prescribed for. Intentionally or unintentionally this component of care, marked by uncertainty, establishes mental illness as indefinite or permanent in the perceptions of many patients and their carers. This practice provides an explanation of illness that the ill individual cannot envision an end

to, as well as a notion of selfhood that depends on taking medication to be ‘normal’. The expressed fears around taking medication (ibid.) are worsened when patients report side-effects which are disruptive to their day to day life. Numerous patients reported constantly feeling ‘*heavy*’, ‘*tired*’ and ‘*depressed*’, whilst others were distressed by rapid weight gain, hair growth and bodily tremours. Arguably physicians face difficult choices in the allocation of psychiatric drugs due to supply, which has an adverse impact on the patients they care for. In Fiji a majority of psychiatric drugs are provided free (Chang 2011) however the availability of various drugs is inconsistent. Psychiatrists are then placed in positions where they have to decide to prescribe medication they know has worse side effects due to the almost depleted supply of a more desirable drug, which they feel must be *saved* for more acute cases.

However patients’ own decisions to cease medication, due to the decline in symptoms or side effects, were not the only factor in non-adherence to medication. Surprisingly common were the times patients presented at clinics because of relapses, only for family members to admit *they* had not seen the need to renew prescriptions or continue ensuring the patient had taken their medication: ‘*he had gotten better*’ or ‘*we went to church and prayed*’ was frequently the justification for such decisions. This attitude reflects the foreign nature of continued medication, specifically in the absence of symptoms for many. Additionally it reveals disconnects in the understanding of mental illness and reflects issues of communication between families/patients and mental health professionals. Contextually such exchanges can also be understood as connecting to a long history of distrust, specifically for iTaukei patients, around hospitals which have long been understood as ‘*vale ni mate*’ (house of death).

## **TRADITIONAL MODELS OF TREATMENT**

I have talked at length about medical treatment, specifically about the permanent presence it comes to have in the ill individual’s life. In contrast I will now touch on the spiritual/

traditional models of treatment and how this form of treatment is built on the ideal of 'healing' an individual definitively. Traditional and spiritual treatments are sought through spiritual healers, institutions and practices. This is inclusive, but not limited to religious priests, traditional 'herbal' priests and places of worship such as churches, temples. I learned quickly that individuals actually have diverse definitions of spiritual and traditional healing and rarely place emphasis on clearly distinguishing boundaries, as there is a large area of overlap. Additionally a witchdoctor was another healing figure that evaded clear confinement to a category and was at times considered as both traditional and spiritual or occupying a different arena all together.

The term 'spiritual treatment' was used in reference to practices such as prayer, confession and exorcism. It is important to note that 'religion' was not a commonly used term by informants when they described seeking help through faith based healers. Spiritual treatment in addition to religious healers and witchdoctors did commonly involve *pundits* (Hindu priests). Traditional healing accounts were marked as distinct from spiritual healing only when one focused on accounts of 'herbal medicine', which included healing through the use of various plants and massage.

Gathering information on traditional healing is difficult, due to the secrecy and power of such knowledge (Katz 1999). This is a shortcoming in my own research I must acknowledge. Whilst the prevalence of these systems of healing exists within Fiji and patients admit to using such treatments, little was discussed in depth about such practices with me during my research (for more insight into this topic see Becker 1995; Katz 1999).

Traditional and spiritual healers are often explained as holding more facilitator-like roles during treatment with ill individuals, rather than the expert-and-lay individual relationship that defines psychiatric care (Finkler 1994). Additionally spiritual and traditional treatment modes are focused on healing. Both these models often engage with social, historical, cultural and economics contexts of sickness, versus the eradication of disease that is often central to the biomedical model (Waldram 2000).

## THE POWER OF PRAYER

The presence of religion, specifically Christianity, in the provision of psychiatric care is visible throughout the hospital. This should be no surprise, due to the integral place of religion within Fijian life (Tomlinson 2007; Tomlinson 2014). Within the hospital settings individuals regularly engage in prayer. Most frequently prayer is engaged in during occupational therapy and services for Methodists and Catholics are provided on the weekend. Furthermore faith based organisations, specifically Christian ones, have a strong presence in mental health care initiatives and support.

At the first signs of illness, individuals were often taken to the church or a temple to be prayed over. Prayer as a tool of healing mental illness was inescapable. It was encouraged to patients within St Giles, by nurses and their fellow patients and was engaged in enthusiastically. I occasionally found myself in prayer with others, who would ask *'pray for me'* or would tell me, *'I will pray for you and your family.'* Prayer was engaged in individually and collectively. Those of Christian faith often explained that the priest would bless them and encourage them to ask for forgiveness for their sins. Additionally outpatients reported that at times groups from the church would visit them and pray for them collectively.

Despite the prominence of Christianity within the psychiatric setting, Hinduism was also commonly practised, although markedly less amongst inpatients who were largely Christian or Catholic. Hinduism was practised by a dominantly Fijian-Indian population and many of my informants who were Hindu were outpatients.

When recounting forms of treatment, Hindus would often recount visits to priests for the blessing of various objects (strings and charms) for the ill individual to wear or food for them to offer in prayer. Fasting was also common amongst both religions, which was engaged in with regular prayer. Distinct from psychiatric care, prayer allows an individual to actively engage in their care and treatment through a practice in which they are competent.

Prayer is often used in complement to medication, however there are times where prayer is encouraged above all and in supplement to medication. Stories of such treatment decisions were often heard when patients would appear in clinic, after failing to attend for months or at times a year, having now returned because they had become ill again. The case often was that a patient's symptoms would have disappeared and the individual, their family and their place of worship would agree that medication was no longer needed, only prayer.

Prayer was often a readily provided explanation as a form of healing mental illness. I believe the easy discussion around such a practice relates to the normative and regular nature of prayer in everyday life. Despite the conflict that can arise between religious practice and the medical system, I would argue that in the case of psychiatric care patients are encouraged to remain true to their faith. Religion itself is often used as a point of encouragement for one to get better. This was visible often when I attended occupational therapy classes in St Giles.

I recall one morning, I was seated in a circle with a group of eight women and a mental health nurse. The nurse Laloma, a middle- aged Fijian woman, was speaking with a woman, Sara,<sup>4</sup> asking her what made her happy. Sara replied to her that prayer makes her happy. Sara was having a difficult day, it was visible she was anxious about the length of her stay in hospital, now approaching, to my knowledge, nearly two weeks. Sara was eager to return home, but the staff were still not sure she would be able to, as she still had difficulty taking her medication and her self-care was poor.

I watched as she spoke, Laloma comforting her softly, explaining to Sara what she needed to achieve before she could leave. Appealing to the value of her faith as an incentive to actively engage in her treatment. *'You need to be healthy for your faith'*, Laloma told her passionately, Laloma is a devout Christian herself. In this same occupational therapy session, like many others, we prayed for each other, our families and our health or gave thanks for what we had.

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<sup>4</sup> Please note a pseudonym has been used here.

Priests also played an important role when individuals sought spiritual treatment, with certain priests willing to engage in various practices such as exorcisms or other healing rituals that involve more physical and sometimes violent practices. I found that patients and families were very hesitant to share visits of this nature and I never attempted to push discussion. As a result a large portion of these accounts came from medical staffs' own experiences with their patients and their carers.

I was told priests performed exorcisms in order to remove the devil or dark spirits possessing individuals; this is a practice that appeared to be viewed unfavourably. When discussed with me, the staff members often shared stories in hushed and wary tones, and the nature of the stories were often traumatic. One nurse explained to me that her patient had presented with deep lacerations all over her back and on her arms from lashings and being bound. Similar accounts circulated around pundits, as I was told of a patient who had arrived at the hospital, reportedly having been whipped and having had a piercing through both her cheeks, which had previously had a metal bar fed through it. These forms of treatment were viewed warily, and despite being willingly sought were often defined by the uncertain nature of how the healer would treat the ill individual.

Despite these alarming accounts, religious healers and prayer are largely understood and seen as allowing one to make sense of one's life and illness. Prayer allows the reframing of one's life in the face of pain, it allows the ill individual to engage in a dialogue of suffering and create purpose from such pain (Luhmann 2000).

## **TREATMENT: IN FLUX OR FOREVER**

The biggest distinction between treatments and an important facet of the stigma are the implications of treatment for the ill individual. The *recognized* success of treatment confirms the correlating illnesses, signaling an individual as possessed, cursed or mentally ill. Sickness in this exchange is inseparable from treatment, as treatment indicates whether an individual can be healed and if so to what extent. Here is where the clear distinction between psychiatric



explanations and competing healing systems emerges. McGruder (2004) explains that the reason there is a lack of stigma around patients suffering schizophrenia within Zambia is because it is largely understood as spirit possession. Understanding illness as possession creates the expectation that the illness can be removed and the ill individual can be returned to good health, largely unchanged (Good 1997). However, mental illness in comparison to spirit possession in Zambia is seen as permanent and inseparable from the person, mental illness sees all personal agency stripped from the individual (McGruder 2004). This understanding of a psychiatric diagnosis as permanent and spirit possession or a curse as temporal, was very much visible in my own research.

Treatment through the differing models of biomedicine or traditional and/or spiritual takes on a very different meaning; where spiritual and traditional treatments are curative and psychiatric treatment is one of permanent symptom management. The traditional illness model offers hope to the individual and the community, with the individual being understood to be able to return to the way he or she was before. The biomedical model in contrast establishes the individual as irreversibly different, inferring more than often that their difference makes them somehow less complete.

Illness and the nature of treatment therein shape future trajectories for individuals and their families. How mental illness is constructed and treated explicitly indicates how one can expect to live out one's life. It dictates what the ill person can see themselves entitled to, capable of and what they can expect to be subject to. For many diagnosed mentally ill individuals within Suva, being diagnosed and then treated through a mental health service meant that large parts of the population saw them as unsafe, unmarriageable, unemployable and largely non-existent within social life. More concerning on an individual level was that mentally ill individuals started to see themselves this way too. Stigma is unarguably connected to mentally ill individuals, which is not to say that spirit possession or being cursed exists outside of stigma.

However, individuals who were possessed or cursed were never visibly discriminated against with such intensity. Speculatively it could be said part of this response related to the reversibility of their sickness, indicated by their treatment. Exacerbating or potentially fueling stigma around mental illness is the focus on psychopharmacology, which is recognized to have adverse effects and fails to engage individual narratives of illness. As Luhrmann (2000) points out, psychological explanations of mental illness can reduce stigma, but only if they engage both psychotherapeutic and psychopharmacological approaches. The adverse side effects from medication and the long-term duration of medication are starkly different from the short-term nature of other various traditional and spiritual treatments. However this is not to romanticize spiritual and traditional treatments, which too have been reported to be deeply traumatic.

### **PART 3: A ST GILES CASE**

#### **MORAL EXPERIENCE: WHAT IS AT STAKE?**

Limited studies (Aghanwa 2004; Chang 2011) have shown to varying degrees that stigma is a persistent issue in modern day Fiji. My own fieldwork supports the reality that stigma is a serious issue within Fiji, having adverse effects on the ill individual, carers, families and mental health professionals. Stigma negatively shapes lived realities for individuals, discrediting identity and displacing roles within social networks. Stigma erects social barriers to employment, housing, legal support and health care, whilst on a personal level individuals are rejected from the family unit and their communities. Discrimination around mental illness also extends to families, who are opened to public scrutiny and ridicule because of their connection to the mentally ill individual or their potential role in causing illness. Additionally, for mental health professionals there is internal stigma within the medical professional, with colleagues often encouraging mental health workers to leave the mental health sector to *‘get out before you end up mad like them.’*

In the beginning of this thesis I introduced analysing stigma through a moral experience approach (Yang, et al. 2007) with the intention of exploring the impact stigma has on the everyday lives of mentally ill individuals and those connected to them. Experience, Kleinman (1998) argues, is moral because human actors are deeply engaged stakeholders in everyday life with things to lose, gain and preserve. It is the potential threat of losing our world, through forced displacement or historical displacement which creates a feeling of ‘grief, a cultural bereavement’ and is what causes one’s attention to be centred on one’s everyday life, which is at constant risk of disappearing (ibid.).

By engaging moral experience as a framework to discuss stigma we move beyond stigma as simply a linear relationship of stereotype, prejudice and discrimination. Instead exploring stigma through this lens allows a much more complex, relational account of stigma, one that is anchored in the lived experiences of individuals who are faced with or enact such exchanges. Through this approach stigma can be seen as intersubjective. Yang, et al. (2007)

argue it is through interpersonal communications and lived engagements at times that matter most—through words, feelings, gestures and meanings—that stigma occurs. Through an intersubjective exploration of stigma we are exposed to a deeply social and subjective phenomenon.

## **THE MARK OF SHAME: ST GILES**

Less than two decades ago Aghanwa (2004) argued that stigma failed to appear to be a *major* concern around mental illness within Fiji. However currently in modern day Fiji stigma has become a central topic of discussion and focus for many mental health stakeholders. This shift arguably can be tied to the increased psycho-education around mental illness, which research has found increases stigmatising attitudes around mentally ill individuals (Angermeyer, et al. 2011). Biomedical explanations around mental illness explain the illness as being the result of various biochemical imbalances in the brain, as well as individuals being more susceptible due to a family history. These examples can result in individuals' seeing the mentally ill individual as permanently damaged, defected or simply unpredictable and uncontrollable. This treatment from others to the mentally ill individual is often the focus of discussion on stigma. Attention is centred on the stigma faced by individuals who have been diagnosed with a psychiatric disorder and the way they are treated as a result of this diagnosis.

For many individuals, being diagnosed with a mental illness often results in being rejected from the community and family unit (Sivakumaran, et al. 2015). Additionally St Giles' history and current position within Suva occupies a deeply negative place in the Fijian imaginary. Therefore public stigma is not only directed at mentally ill individuals but place stigma, that is the stigma that is attributed to a place or location, exists around the hospital. Various forms of stigma are interrelated and supportive of each other in the realm of mental illness and health. Stereotypes around mentally ill individuals negatively portray the patient population of St Giles, whilst simultaneously stigma around St Giles negatively impacts how the public view patients who seek help at the hospital.

A direct example of negative attitudes and prejudices around mental illness and St Giles Hospital is reflected in the label ‘St Giles Case’. This term characterises patients of St Giles Hospital and by extension mentally ill individuals as violent, unpredictable, uncontrollable and ultimately incapable of existing ‘normally’ within society. This negative construction of mentally ill individuals simultaneously establishes the individual as a dangerous threat to members of the community’s own existence and safety. This stereotype whilst grossly misrepresentative of mentally ill individuals is supported by the historical function and role of the hospital within Fijian society. St Giles Psychiatric hospital was previously established as Fiji Lunatic Asylum and was where various social undesirables, criminals and murders who were diagnosed with lunacy were housed (Leckie 2010).

Current prejudicial notions of mental illness are misinformed due to the lack of understanding around mental illness, which is the result of discrimination and distancing from the stigmatized group. As Hinshaw (2007: ix) explains:

*‘creating distance from the person in question, and even putting that person down, can preserve self-esteem and ward off the threat, at least in the short run. Yet the distancing and rejection serve to magnify fear and ignorance, creating a vicious cycle.’*

Whilst understanding aspects of what informs and constructs labels such as ‘St Giles Case’ are important, the more pressing question is how do such stereotypes, accompanied by acts of discrimination, shape the lived realities of members of the stigmatized group. What does it mean to be an individual recognized as a ‘St Giles Case’? And how does such a label shape his or her world, if at all?

Stigma is intersubjective and bound by context and has a negative impact on negotiating the lives of mentally ill individuals. In the following discussion I would like to explore accounts of experiences of stigma, focusing on why and how acts of discrimination occur, whilst also inquiring how the stigmatized individual receives such treatment. Additionally, I wish to look at how public stigma can become self stigma and the impacts self stigmatisation have on the mentally ill individuals’ subjective experience and place within the world they

live in.

### **PIO: ST GILES TRUE**

*'They call me St Giles true'* Pio explained as he looked away from me. *'Why?'* I asked. *'They laugh when they see me in public, they point and talk. People discriminate. They treat you different. They repeatedly don't believe you.'* Pio did not answer my question of why. Instead he continued to talk about how people treated him as a result of being labelled a 'St Giles Case'. Pio was a Rotuman man who was likely in his early forties or late thirties. His hair was a black tangled mess and his face was covered by a thick dense beard and glasses which were dirty and smudged. He was currently homeless and residing in a home designed to support individuals living with disability. Pio has been diagnosed with paranoid schizophrenia and because of the severity of his illness is not able to care independently for himself.

Pio had first become sick during his second year of medical school, when he had been diagnosed with depression and as a result started on antidepressants. Three years later he had stopped sleeping and started to hear voices, as a result he was taken to St Giles and admitted. Upon his discharge two weeks later he had a new diagnosis—paranoid schizophrenia. Pio's father had cared for him as he struggled through the chaos of his illness, which resulted in various clinic visits and hospital admissions.

Pio's father died seven years ago and he had been left with his two sisters, who took over the responsibility of his care. However the way his sisters cared for him was very different from his father. Pio explained they would lock him in the apartment if they ever left the house, padlocking the front door. They felt he was lazy and did nothing so they would often beat him with a stick or a hosepipe. Shamefully, he explained to me, he started to soil himself when his older sister—she was responsible for a large part of the abuse—was near him. *'It was with the power of her mind'*, he described that would make him lose control. *'I tried to tell the doctors at the clinic'*, he explains but no one did anything. Last year he ran

away, for a while he had nowhere to go and then he had found St Vincent House and has stayed there ever since.

## **TO BE LESS THAN HUMAN**

In Fiji being diagnosed or perceived as mentally ill places the ill individual in an exceptionally vulnerable place and has the potential to cause deep harm. Mentally ill individuals are perceived as less than human, as somehow intrinsically different from other members of Fijian society (Aghanwa 2004). As a nurse explained, to be mentally ill is '*like a brand on your birth certificate*'. This parallel was frequently made about mental illness, with it also frequently being called a '*death sentence*'.

Mental illness does not only threaten a person's physiological and psychological wellbeing, but their place within society, their relationships, their sense of community and self and their hopes for the future. By establishing the stigmatised individual as less than human, negative acts and discrimination can be justified and supported irrespective of the adverse effects they have on the stigmatised individual's life chances (Goffman 1963). Stigma is cited by many mentally ill individuals as a central concern around their illness (Reavley and Jorm 2011). Stigma doubles the burden mentally ill individuals face; they must not only deal with the physiological and psychological impacts of their illness, they must now also negotiate the hostile and demeaning treatment from the broader community and possibly the family unit (Corrigan 2002).

Pio's story in many ways is reflective of the various types of treatment individuals are subject to as a result of negative perceptions of their illness. Violence was commonly reported as utilised against patients, some patients openly talked about such treatment and others offered hushed confessions. Conversations around violence were often dependent on the severity of abuse and whether the patient still lived with the abuser. If they did they were often more hesitant to discuss such things. Within Fiji violence is a serious social issue and holds a historical and normative place in everyday life, with violence often used as a means of

control or being reflective of various power inequalities in wealth, status or gender (Naidui et. al. 2005).

This is evident in the various occasions in which carers would admit to hitting their charges, as one mother described regarding her daughter, '*she is enough to send me to that loony bin (St Giles). At home, it is not a normal home anymore. Everything is under duress.*' It is in this environment, where her daughter is '*always screaming*' that she explains '*I punch her and hit her.*' Violence can be further justified I believe by the prejudice that mentally ill individuals are not the same as 'us'; that they do not feel the same way, do not have the same needs or understand and communicate in the same way. Additionally historically and culturally various violent treatments have been used to treat mentally ill individuals (Leckie 2004; Leckie 2005), which contributes to further normalising such violence. This prejudicial attitude is called *authoritarianism* where the mentally ill individual is established as inferior to the normal individual and requires coercive handling (Cohen and Struening 1962:354).

A prejudicial authoritarianist attitude can be used to describe various other forms of treatment practised within Fiji. Mentally ill individuals are confined within their homes, others are exploited within the family unit, they are reduced to servant like status being made to cook and clean. A nurse once described to me how her family treated her uncle who was mentally ill. '*They treated him like a slave. They saw him as nothing.*' Her uncle, she remembered, was sent everyday to work in the plantations because he never got tired, but if there was ever a shortage of food he would be the one to miss out so others could have a little more to eat. Acts of discrimination were often tied to personal feelings of humiliation, shame or even fear felt by family members as a result of a relative's mental illness. The same nurse explained to me her own '*mother did not want him (her uncle) to be seen as her brother.*'

## **A FAMILY'S SHAME**

While exploring stigma as intersubjective, an important question is what perceived threat is associated with the mentally ill individual? What is at stake for family members and/or the



family unit by having an ill family member that allows them to engage in otherwise unacceptable behaviour? What are family members trying to preserve through discrimination? Many families experience embarrassment and shame over mentally ill relatives, engaging in various measures to conceal their mental illness from other members of society (Thirthalli and Kumar 2012).

As mentioned previously (see Part 2) the cause of an individual's mental illness can implicate family as having had a role in the occurrence of the illness, often as a result of ancestral moral failings. Because of shared etiological beliefs stigma can then extend to encompass the family as well as the individual, establishing both the family and the ill individual as morally deficient (Yang, et al. 2007).

Suva is a small city and the social lives of individuals are intertwined through various social relations and networks. Therefore the threat and spread of information about a family member's illness is ever-present with very real ramifications for the family unit and the ill individual. Mental illness within a family threatens a family's social status and brings scandal to the family name, which is deeply important to many individuals within Suva. To be mentally ill not only threatens the individual's hopes for marriage but also other family members, as members of the public are often unwilling to marry into a family where someone has a mental disorder (Reavley and Jorm 2011). Many family members are concerned they will suffer the same exclusion as their mentally ill relative due to their familial connection (Thirthalli and Kumar 2012). They fear being pushed to the fringes of society, being denied the same rights, respect and affection a 'normal' human being takes for granted in every day exchanges.

## **THE NON-HUMAN AND THE PUBLIC**

When stigma around the mentally ill acts to reduce someone to a less than human status, the magnitude of what this implies, I fear, is sometimes lost. To not be seen as human takes away basic human rights: one's right to shelter, food and clothing, furthermore you are denied love,

affection and protection. You are villainised on no violation of your own but simply for who you are; by the broader community, mentally ill individuals are often treated openly with fear, hostility, taunted or jeered at. Alternatively they are seen as clowns, laughed and ridiculed, often shoved and harassed, ‘just for fun’ an informant explained to me, in order to elicit a response. The extent of how far one can fall in the eyes of society due to having a mental illness was first crystallised to me during a home visit to see a patient called Vilu.

### **A HOME VISIT WITH VILU**

A man stormed into the house, brandishing an umbrella and screaming. I stopped my interview with Vilu, startled, turning to the man as he stood in the entrance of the house swearing. ‘*She is a whore, she sells herself to anyone who will take her!*’ he was shouting by the time I registered what he was saying. ‘*You*’, he accused the CPN team—a mental health nurse, our driver and the psychiatrist—‘*are not doing your job right.*’ Vilu cowed as the man pointed his umbrella across the room at her, ‘*Thief! She comes into my house and steals and no one stops her! You need to control her.*’ Everyone was transfixed by the furious and hateful man in the doorway, barely registering that Vilu had now risen and turned to escape through the back of the house. Felix, the intruder, continued, more interested in having the attention of the CPN team than pursuing Vilu, ‘*I threw urine in her face, if she comes near my house again I will throw acid next time.*’ The statement horrified me and I watched as Dr Riana interrupted him to ask who he was. The man identified himself as Felix, stating he was Vilu’s neighbour, pointing to his house, visible from the front window of the lounge room we sat in.

Stigma around mental illness morphs the individual into someone less than human creating a devalued identity that justifies gross mistreatment. The threats made by Vilu’s neighbour, her brother later told the CPN team, were not new, sometimes Felix would even hit her. Whilst I believe Vilu’s neighbour is an extreme case of how mentally ill individuals can be treated by close community members, I was more confronted by the lack of concern

expressed by Vilu's family over the abuse she faced from their neighbour. This exchange is reflective in many ways of what it means to be a non-human. Stigma establishes the mentally ill individual as without the moral entitlements enjoyed by 'normals', such as 'function, a sense of place in an intersubjective world, empathic connection with reciprocating others, peace of mind, happiness, participatory citizenship.' (Johnstone 2001:200).

The loss of participation in an intersubjective world is visible in the way mentally ill individuals are discouraged or excluded from engaging in the social world. This exclusion and discrimination is enacted over varying levels, through institutions such as hospitals, universities and the legal systems, additionally by various individuals who make up one's life world (Taket, et al. 2009). One patient explained to me woefully, '*the nurses they tell me not to marry again, but I get lonely Tasha.*' Individuals diagnosed with mental illness are often discouraged to marry, due to perceptions they are unable to fulfill marital roles or are now an undesirable spouse. Additionally the threat of being excluded from employment or fired from one's job is also very real. Many outpatients explained they kept their mental illness a secret in the workplace, concerns with being looked at differently or perceived as incompetent, lay at the heart of this decision. One informant explained to me how her sister had been asked to leave her post at a university when they had been made aware that she was diagnosed with depression.

Whilst these forms of stigma played out through large institutions, various forms of stigma worked to ensure the mentally ill individual would not pursue engagement in the broader social world. On occasion mentally ill individuals were not told not to have children, as they would not be able to look after them, this was often supported by legal rulings. One informant explained how she herself had been placed in an orphanage because her mother was sick and could not care for her, and she had no family willing to take her in. Another area of great concern for individuals was continuing education if one had become sick during schooling. Often individuals were discouraged by their family and at times nurses and physicians to give up school in order to reduce stress. One woman explained to me, '*I got*

*sick during school, so my family they burnt my books and I did not go back. Instead they gave me magazines to read so I would not stress.*’ Many individuals are seen as not ‘stable’ or ‘capable’ of completing education if they have suffered a mental illness, specifically if during the time of schooling. One informant explained she was in her last year of university and had painstakingly made sure no one knew of her illness as she feared she would not have been admitted if they knew.

Stigma attacks an individual’s personhood, constructs them as less human, less capable and less deserving. Stigma curbs life chances and ensures the continued marginality and isolation of the individual, actively preventing individuals from developing intimate relationships, having families, pursuing work and education, creating a life where one’s prospects are near invisible. This often leads to feelings of hopelessness, shame and encourages one to withdraw from the social world, as an act of preservation or fear.

### **THE SEVERITY OF STIGMA AND THE ACCEPTABILITY OF STRESS**

When discussing stigma it is important to understand that it varies with intensity. The stigma around mental illness within Fiji is often connected to the severity, behaviours and diagnosis of the mentally ill individual. This is visible in research in Australia, where participants perceived persons with schizophrenia as more dangerous and unpredictable than persons with any other mental illness, expressing the greatest desire for social distance from such a group (Reavley and Jorm 2011). I would argue this is true also in the case of Fiji. Schizophrenia is often how people conceive mental illness, with stereotypes of mentally ill individuals as dangerous and unmanageable often extended to define all inpatients admitted to St Giles Hospital. Alternatively ‘anxiety’ and ‘stress’ were never viewed with the same negativity or intensity as schizophrenia. This was apparent in the way inpatients and the public viewed the Stress Management Wards found in regional hospitals.

The stigma around the SMW is markedly less with the ward often seen as a place *‘where people who are stressed come because they need to relax’*. The SMW does not have

any of the stigmatizing labels associated with St Giles such as ‘mad house.’ The eight-bed ward was designed to house patients with mild cases of depression, anxiety and stress, however in practice the ward received an array of patients with various mental illnesses. Yet the SMW was a preferred place to be admitted, with patients from St Giles requesting to be transferred to the ward. Often when a patient is admitted or transferred to SMW they receive visits from family, who have never visited them before as an inpatient at St Giles.

I argue that two main factors facilitate the decline in intensity of stigma around mentally ill individuals: the location of the ward, which is found within the general hospital, and the acceptability and reliability of ‘stress’ to others. Stress for many is a naturally encountered emotion in everyday life, whilst mental illness is viewed with fear as it has the potential to place one’s life in great threat.

Stigma evidently exists in varying intensities and these intensities are influenced by various contextual factors. Additionally the impact that stigma has on the individual depends on the context within which the individual finds himself. For example a mentally ill individual who has a supportive family is less vulnerable than a homeless individual. Alternatively a patient with mild depression who can live his or her life largely undisturbed seems to avoid being subject to the ridicule and harassment of a patient who is known as having been diagnosed with schizophrenia.

The stigmatiser and the stigmatised exist in larger political, social, and cultural worlds, they both have their own values and motivations which shape their expectations of mental illness and how the mentally ill individual should be treated (Pescosolido, et al. 2008). However the intensity of stigmatisation is hugely influential on the life course of an individual. Stigma not only threatens one’s place in the social world, but the acceptance of strong prejudicial attitudes negatively impacts on how mentally ill individuals see themselves and the life they are worthy of.

## **SELF STIGMA TIES YOU DOWN**

Self-stigma is arguably one of the most detrimental results of stigma. This phenomenon occurs when the individual recognises and accepts that this stereotype applies to him- or herself. (Ehrlich-Ben Or, et al. 2013). Self-stigma greatly devalues the mentally ill individual's identity and has various negative effects on a person's day-to-day life. When asking what is at stake for the stigmatized individual, self-stigma is one of the greatest and most often overlooked threats.

Concern is often centred on public stigma, on the social ostracism of an individual, but attention to how stigma becomes internalized and comes to be enacted and believed by the ill individual is limited in comparison. Public stigma facilitates self-stigma, as it is the fear of rejection that leads the stigmatized individual to withdraw from society (Ritsher and Phelan 2004). As self-stigma intensifies, the stigmatised individual often comes to view limited or no prospects for their life (Lysaker, et al. 2007). They see themselves as defined by their illness, which often involves accepting beliefs they are inherently less worthy than others around them.

Self-stigma has various impacts on the individual, playing a role in shaping the course and nature of the illness, treatment success and continuation as well as impacting concepts of self and hopes for one's future. Research has show that self-stigma worsens psychiatric symptoms (Lysaker, et al. 2007), deters people from seeking treatment for mental illness (Lucksted and Drapalski 2015) and discourages the continuation of treatment, often encouraging the self-management of illness (Ehrlich-Ben Or, et al. 2013). On a more personal level self stigma erodes positive attitudes about one's capabilities and self (Vogel, et al. 2013), decays hope (Chan and Mak 2014; Lysaker, et al. 2007) and leaves individuals unwilling and unable to pursue life opportunities (Corrigan and Watson 2002). Self-stigma is argued to diminish a person's quality of life, as individuals often describe their lives as defined by hopelessness or as being meaningless when they hold self-stigmatising beliefs (Ehrlich-Ben Or, et al. 2013).

Self-stigma is the acceptance and incorporation of stigmatising attitudes into one's identity. Through a continual and systematic discrimination—from families, the community, the legal system, health care systems and employers—individuals come to believe that they are less deserving of certain resources, treatment and even affection. Furthermore, shame is often an integral part of how ill individuals see themselves and their life. Goffman (1963:18) explains this sense of shame arises from ill individuals being aware they possess a deeply defiling attribute, one the stigmatized individual can clearly wish himself without.

Many individuals are aware of the way their lives drastically changed due to their illness, yet they are also aware of how stigma works to capture them in positions that ensure returning to the lives they previously enjoyed is near impossible. Eventually they even come to believe this, it is not prejudice or discrimination that hinders them from achieving this desired life, instead it is who they are and their illness that makes such desires unachievable. Defined as “a painful mental feeling aroused by a sense of having done something wrong or dishonorable or improper,” shame is fueled by the intensely social nature of life and by humans' self-reflective tendencies, which result in internalized devaluation when one does not live up to social or moral standards (Hinshaw 2007:36).

## **AN UNLOVABLE SELF**

Self-stigma was visible amongst many mentally ill individuals I encountered in Suva. Often individuals did not realise they were engaged in such acts of discrimination against themselves, as various beliefs around 'inferiority' or 'inability' have become entrenched in how they see themselves. Many outpatients spoke of feeling 'small', voiced concerns about being unlovable and shared anxieties of being worthless. Teo<sup>5</sup>, a young Fijian man explained to me, defeated, one day, *'I am stupid. I am an embarrassment.'* Mary, another informant, explained to me, *'I'm not good at anything.'* These beliefs reflect the worthlessness and anxiety created by self-stigmatising behaviour, behaviour that often goes unnoticed or is

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<sup>5</sup> Please note a pseudonym has been used here.

encouraged because these acts of self discrimination conform to broader stigmatising attitudes and practices.

Alternatively, self-stigma has been the instigator of self-advocacy and the rejection of stereotypes as mentally ill individuals express the injustice and destruction caused by discriminatory practices. Corrigan and Watson (2002:64) explain this is the fundamental paradox of self-stigma, the feeling of righteous anger at one's discrimination, whilst also feeling the low self esteem that self-stigma causes.

However before addressing the nature of 'righteous anger' amongst mentally ill individuals, I want to discuss how self-stigma shapes the lives of ill individuals. Expressions of self-stigma were voiced in a variety of ways. One informant explained to me sadly, that she would never marry, replying to my question of why? with '*I can't. I am sick.*' Another informant confessed desperately all she wanted in life was a family who loved her and her great fear in life was she never would have one because of *who* she was.

Unexpectedly one outpatient explained she would love to travel but couldn't because she was not allowed to leave the country, she had been led to believe mentally ill individuals weren't meant to travel because they were dangerous and other countries wouldn't take them. Other stories were more complicated, as one informant explained, she had left a husband who beat her viciously and regularly, but the court had assigned him full custody over their two girls as she was mentally ill. Whilst deeply saddened, she was resigned to the loss of her children under the explanation that she was not fit to look after them.

Self-stigma ensures individual's lives become bereft of a sense of agency, creating fatalistic outlooks and diminishing motivation about one's future (Kinderman, et al. 2006). Stigma changes perceptions of how individuals see themselves living and engaging with the world, however it also changes how they feel about their world and those around them and how they understand others to feel about them. Emotions that define one's sense of place in the world are feelings of fear, unease and helplessness, which reinforce desires to avoid and withdraw from social interaction (Chan and Mak 2014). This is visible in how individuals



hold themselves, the spaces they occupy and their willingness to be seen associated with certain groups.

Yang, et al. (2007) explain that stigma expresses and manifests through gestures, words and bodily states. Bodily exchanges which involve physical distancing—such as leaning away or not coming too close—or refusal to touch a mentally ill individual are not uncommon. In fact I observed this spatial and bodily separation to be present among non-mental health trained physicians and nurses.

Self-stigma, through this treatment, becomes imbued with the belief that one should not take up space, enter certain spaces or approach certain groups. Additionally this means individuals do not expect affection or cannot imagine intimacies would be extended to them, even though they may secretly and desperately yearn for such. Mentally ill individuals, specifically those who have poor support networks are often robbed of small intimacies that we take for granted in every day life. The genuine interest in one's wellbeing, the comfort of a hug or the security found in a loved one's support becomes a distant memory.

## **SMALL INTIMACIES**

One of the greatest threats of stigma that I witnessed in my fieldwork was the damage it does to an individual's sense of self, how they feel, engage with and understand their place in the world. If we explore stigma as intersubjective, then we must also realize the impact this relationship can have on individual subjectivity. Luhmann (2000:20) engages with the way external forces shape the internal through the concept of the 'transformation of subjectivity'. The transformation of subjectivity, Luhmann (ibid.) explains, is how an individual comes to understand what is needed to be a member of a group, how he or she learns what to react to, how to react and also what to come to fear. Luhmann (ibid.) applied this to her observation of non-psychiatric resident doctors who over the course of years learnt to become qualified psychiatrists, through being taught various ways of seeing, knowing and engaging. Her

account echoed with similar exchanges I witnessed between many mentally ill individuals and various social actors.

Continual negative exchanges by mentally ill individuals with family, friends, mental health professionals, community members and institutions shaped new ways of understanding themselves and their place in the world. To simply say stigma leads to negative self-thought or decreased self-esteem disengages with the real suffering. Stigma can teach people they are not worth loving, deserving of gross abuse and discrimination and undeserving of intimacies or simply human contact that we as human beings deeply crave. I came to realise the magnitude of such loss in the face of stigma through a young woman called Esther.

Esther and I were similar in age, and through the course of my fieldwork she was a patient at SMW for two months. We came to know each other well and she became more a friend than an informant. Esther was engaging and inquisitive, she made friends with patients and the nurses on the ward quickly and was well liked, however there was always a sense of reservation about her, a distrust of others was visible as she kept most things to herself. I felt this could be a result of an abusive and turbulent family life, the result of various betrayals she had encountered from friends and discrimination and rejection she had faced due to her illness. Our friendship grew slowly and at times I could still sense her hesitancy, until one day I believe our comradeship reached a new level and opened me to a new perception of the devastation of stigma on individuals who suffer from mental illness.

Esther and I sat beside her hospital bed on a bench talking, I had complemented her on her hair, which she had done in a complex updo and she asked, 'can I do yours?' I was surprised that she offered due to her reserved nature but happily agreed. Laughing that I could not remember the last time someone had played with my hair, Esther was quiet in response to my comment and looked at me uncertainly, 'really?' was the timid question put forward. The easiness of the conversation had disappeared and I was surprised by the vulnerability that I was witnessing. Esther looked at me with a mixture of embarrassment, apprehension and fear. I was struck by the turmoil such a request had resulted in, the gravity my reply held and was

uncomfortable by the visibility of various inequalities in our relationship. More importantly, I was exposed to the suffering of a much more intimate kind, a deep loneliness which is caused by various mechanisms of stigma.

Stigma doesn't just 'negatively impact' one's self-esteem or self-worth, but ensures individuals *accept* with quiet resignation that they are lesser and as a result deserving of everything which is denied or taken from them, regardless of their own needs and desires. This acceptance occurs through being subject to simultaneous forms of discrimination and prejudice. Through actions and opinions of family, community and governmental bodies all of whom explicitly or implicitly see you, treat you, teach you and remind you that you are 'broken.'

In the case of Esther, in this exchange, it was small intimacies, gestures of friendship and the extension of trust, which she saw herself undeserving of. She was genuinely shocked that I would let her braid my hair and deeply moved that I let her enter the sphere of my own personal space, where she was in control of a part of my appearance. There is a deep intimacy in the task of braiding hair, it requires varying levels of comfort, faith and trust; comfort in having someone enter one's personal sphere, faith in them to perform the task successfully, as well as trust in them to take care with your person whilst performing such a task.

This exchange opened me to a new way of understanding the lives of mentally ill individuals. Stigma became a more pressing issue, because suddenly the ravages and the heartache of my informant's lives became more unbearable and marked by a deeper injustice. What the mentally ill individual desires is often ignored when we talk about what is lost in the face of stigma. Stigma continues to be a pressing and detrimental issue around mental illness within Fiji.

## **PART 4: CONCLUSION**

Throughout this thesis I have tried to provide an understanding of how mental illness and treatment is negotiated in relation to the diverse beliefs around illness and healing within Suva. In the current day context etiological beliefs around mental illness / madness are produced through traditional, spiritual and biomedical models. Treatment in response to the diverse and often collaborative understandings of mental illness is correspondingly pursued through various treatment avenues.

I have proposed various reasons for diverse understandings around mental illness. Firstly the engagement with both traditional and medical models reflects the shortcoming of the biomedical model. Psychiatric practice within Suva fails to engage in addressing individuals' personal suffering and to provide social cultural frameworks for understanding illness. Nevertheless the use of multiple models establishes socially salient expressions of mental illness/ madness which ensure one's place within the community.

In turn, treatment works to impact personhood in diverse ways. I examined, specifically, the biomedical model. Psychiatric practice and the understanding of illness often result in individuals being understood as permanently damaged and inherently flawed. Additionally I argued that the focus on medication in treating mentally ill individuals often leads to feelings of isolation and powerlessness.

Traditional and spiritual treatments alternatively allow the individual to have a role in their own treatment and beliefs around the permanency of illness are uncommon. Possession and curses see mental illness as limited in duration and reversible through the right avenues. This was the focus of the first half of my thesis: to establish an overview of the diverse manner in which mental illness was negotiated and treated based on various understandings and beliefs within Suva.

My research, which was facilitated through various mental health services also introduced me to the totalising nature of stigma for many individuals who had been diagnosed

and treated within St Giles or, worse, admitted. Stigma is the biggest barrier to mental health services, with many fearing simply being associated with the hospital.

However a greatly overlooked area of the adverse impacts of stigma is the role intense public stigma has on the individual. While I explored the various modalities in which public stigma played out and was produced, the deeply moving and heartbreaking reality that I witnessed was in an environment where mental illness is so heavily stigmatized, individuals who are subject to such constant discrimination *come to see themselves* deserving of such treatment. This is called self-stigma.

Advocacy work within Suva is growing and this hopefully will provide better outcomes in the future for individuals who suffer from mental illness. While the reality of stigma is undeniable, it is not totalising. In conclusion to my thesis I would like to revisit a therapeutic setting. I have mentioned CROP before; this rehabilitation facility provides an invaluable service. CROP promotes confidence, growth, respect and self-esteem amongst the individuals who attend.

CROP has a powerful impact on psychiatric survivors from psychiatric facilities or those referred from clinics. Volunteers and members of YC4MH support the program, which has recently moved offsite from St Giles Hospital. The rehabilitation program provides activities such as sewing, gardening, gym, painting, jewelry making and computing classes. Most importantly CROP functions as a place where individuals gather and talk about the hardships they face, receive encouragement and information as well as being able to interact with other individuals.

Within the walls of CROP, patients are empowered, therapeutically, through the act of developing skills and interacting with others who see and treat them as equals. Here psychiatric survivors provide support and understanding to each other, often connecting over the shared experience of discrimination. I recall a focus group I ran where, after a month, members of the group told me:

Teo: *'Some they say we are mad, but we don't care about them.'*

Mary: *'It is just a word (lia lia) you do not have to believe in it.'*

It was the first time I heard such comments, expressions of resistance and the denial of rigid and toxic stereotypes. Responses from mentally ill individuals which criticised or rejected prejudices had largely been absent in the research I had done within the hospital and clinic settings. In the setting of CROP however individuals were engaged in a compassionate and invested rehabilitation program. Here psychiatric survivors could develop self-esteem and renegotiate a sense of identity, with the ensured support of individuals committed to empowering them.

## References

- Aghanwa, H. S.  
2004 Attitude Toward and Knowledge about Mental Illness in Fiji Islands. *International Journal of Social Psychiatry* 50(4):361-375.
- Angermeyer, M.C., Holzinger, A., Carta, M.G. and G. Schomerus  
2011 Biogenic explanations of public acceptance of mental illness: systematic review of population studies. *The British Journal of Psychiatry* 199:367-372.
- Backe, E.L.  
2013 *Mental Health and Mental Illness in Fiji*. In Emma Louise Backe, Vol. 2015.  
URL:<https://jujujiving.wordpress.com/?s=mENTAL+HEALTH+FIJI&submit=Search>
- Backker-Williksen, S.  
1995 Ceremony and Embodied memory in ubranized Fijian culture. *Bijdragen tot de Taal-, Land-en Volkenkunde* 151(2):218-234.
- Bartlett, N., Garriott, W. and E. Raikhel  
2014 What's in the 'treatment gap'? Ethnographic perspectives on addiction and global mental health from China, Russia, and the United States. *Medical Anthropology* 33(6):457-77.
- Becker, A.E.  
1995 *Body, Self and Society: The View from Fiji*. Philadelphia: University of Pennsylvania Press.
- Bemme, D. and A. D'Souza  
2014 Global mental health and its discontents: an inquiry into the making of global and local scale. *Transcultural Psychiatry* 51(6):850-74.
- Brisson, K.J.  
2009 Shifting Conceptions of Self and Society in Fijian Kindergartens. *Ethos* 37(3):314-333.
- Brundtland, G.H.  
2000 Mental Health in the 21<sup>st</sup> Century, *Bulletin of the World Health Organization* 78 (4): 411
- Byrne, M.  
2001 Ethnography as a qualitative research method. *Association of periOperative Registered Nurses*, 74(1):82-84.
- Castillo, R.J.  
1998 *Meaning of Madness*. California: Brooks/Cole Publishing Company.
- Chan, K. K. and W. W. Mak  
2014 The mediating role of self-stigma and unmet needs on the recovery of people with schizophrenia living in the community. *Quality of Life Research* 23(9):2559-68.
- Chang, O.  
2011 Mental health care in Fiji. *Asia-Pacific Psychiatry* 3(2):73-75.
- Cohen, J. and E.L. Struening  
1962 Opinions About Mental Illness In The Personnel Of Two Large Mental Hospitals *Journal of Abnormal and Social Psychology* 64(5):349-360.
- Collins, P. Y., Patel, V., Joestl, S.S., March, D., Insel, T.R. and A.S. Daar  
2011 Grand challenges in global mental health. *Nature* 475(7354):27-30.
- Corrigan, P.W., and A.C. Watson  
2002 Understanding the impact of stigma on people with mental illness. *World Psychiatry* 1(1):16-20.

- Davies, J.  
2010 Introduction: Emotions in the Field. In *Emotions in the field: The Psychology and Anthropology of Fieldwork Experience*. J. Davies and D. Spencer, eds. Pp. 1-31. Stanford: Stanford University Press.
- Deva, M. P.  
1999 Mental Health in the Developing Countries of the Asia Pacific Region. *Asia-Pacific Journal of Public Health* 11(2):57-59.
- Deva, M. P. and R. D'Souza  
2011 Asian Federation of Psychiatric Services (AFPA) news. *Asian Journal of Psychiatry* 4(2):158-9.
- Devereux, G.  
1957 Dream Learning and Individual Ritual Differences in Mohave Shamanism. *American Anthropologist* 59:1036-1045.
- Dreaver, B.  
2013 Schizophrenic Fiji woman locked in shed for years. *OneNews*, 11 June.
- Ehrlich-Ben Or, S., Hasson-Ohayon, I., Feingold, D., Vahab, K., Amiaz, R., Weiser, M., and P.H Lysaker  
2013 Meaning in life, insight and self-stigma among people with severe mental illness. *Comparative Psychiatry* 54(2):195-200.
- Fiji Bureau of Statistics  
2014 Key Statistics (Fiji Bureau of Statistics). Fiji Bureau of Statistics
- Fiji Ministry of Health  
2011 Strategic Plan 2011-2015. Fiji Ministry of Health.
- Finkler, K.  
1994 Sacred Healing and Biomedicine Compared. *Medical Anthropology Quarterly* 8(2):178-197.
- Flint, A.  
2015 Traditional healing, biomedicine and the treatment of HIV/AIDS: contrasting South African and native American experiences. *International Journal of Enviromental Ressearch and Public Health* 12(4):4321-39.
- Forster, P.M., Kuruleca, S.C. and C.R. Auxier  
2007 *A Note on Recent Trends in Suicide in Fiji*.
- Foster, K., Usher, K., Baker, J., Gadai, S. and S. Ali  
2008 Mental Health Workers' Attitudes Toward Mental Illness in Fiji. *Australian Journal of Advanced Nursing* 25(3):71-79.
- Foster, K., Usher, K., Gadai, S. and R. Taukes  
2009 There is no health without mental health: Implementing the first mental health nursing postgraduate program in FIji. *Contemporary Nurse* 32(1-2):179-186.
- Foucault, M.  
1988 *Madness and Civilization: A History of Insanity in the Age of Reason*. New York: Random House.
- Gluckman, L.K.  
1969 Drau Ni Kau : The Ethnopsychiatry of Fiji in Historical and Clinical Perspective. *Australian and New Zealand Journal of Psychiatry* 3:152-158.
- Goddard, M.  
2011 *Out of Place: Madness in the Highlands of Papua New Guinea*. New York: Berghahn Books.



- Goffman, E.  
1963 *Stigma: Notes on the Management of Spoiled Identity* England: Penguin Books.
- Golberstein, E., Eisenberg, D, and S.E. Gollust  
2008 Perceived Stigma and Mental Health Care Seeking Psychiatric Services 59(4):392-399.
- Good, B.J.  
1994 How Medicine Constructs the Object. in *Medicine, Rationality and Experience*. UK: Cambridge University Press.
- 1997 Studying Mental Illness in Context: Local, Global, or Universal? *Ethos* 23(2):230-248.
- Good, B.J., Fischer, M.M.J., Willen, S.S. and M.J.D Good  
2010 A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities. US: Blackwell Publishing.
- Hahn, RA, and A. Kleinman  
1983 Biomedical Practices & Anthropological Theory, Frameworks and Directions. *Annual Review of Anthropology* 12:305-333.
- Herr Harthorn, B.  
2005 Gender, Health Inequality, and Hidden Healers in Rural Fiji. *Fijian Studies* 3(2):337-356.
- Hinshaw, S.P.  
2007 *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change*. New York: Oxford University Press.
- Inda, J.X. , and R. Rosaldo, eds.  
2002 *Anthropology of Globalization: A Reader*. Oxford: Blackwell Publishers.
- Jenkins, J.H.  
2004 Understanding Fundamental Human Processes. In *Schizophrenia, Culture and Subjectivity: The Edge of Experience*. J. Jenkins and R. Barret, eds. Cambridge, UK. : Cabmridge University Press.
- Johnstone, M.J.  
2001 Stigma, social Justice and the rights of the mentally ill: Challenging the status quo. *Australian and New Zealand Journal of Mental Health Nursing* 10:200-209.
- Katz, R.  
1999 *The Straight Path of the Spirit: Ancestral Wisdom and Healing Traditions in Fiji*. US: Park Street Press.
- Kinderman, P., Setzu, E., Lobban, F. and P. Salmon  
2006 Illness beliefs in schizophrenia. *Social Science and Medicine* 63(7):1900-11.
- Kleinman, A.  
1980 *Patients and Healers in the Context of Culture* Berkeley: University of California Press.
- 1988 The Meaning of Symptoms and Disorders. in *Illness Narratives: Suffering, Healing, and the Human Condition*. US: Basic Books.
-

- 1998 Experience and Its Moral Modes: Culture, Human Conditions, and Disorder. in *The Tanner Lectures on Human Values*. G.B. Peterson, ed. Pp. 357-420, Vol. 20. Stanford University: University of Utah Press.
- 
- 2006 Introduction. In *What Really Matters: Living a Moral Life Admst Uncertainty and Danger*. NY: Oxford University Press.
- 
- 2009 Global Mental Health: a failure of humanity. *The Lancet* 374:603-604.
- Lal, B.  
1995, *Broken Waves: A History of the Fiji Islands in the Twentieth Century*. Honolulu: University of Hawaii Press.
- Leckie, J.  
2004 Modernity and the Management of Madness in Colonial Fiji. *Paideuma* 50:251-271.
- 
- 2005 The Embodiment of Gender and Madness in Colonial Fiji. *Fijian Studies* 3(2):311-336.
- 
- 2010 Islands, Asylums and Communities: Fiji and the Colonial Pacific. in *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800-2000*. W. Ernst and T. Mueller, eds. Pp. 24-50. United Kingdom: Cambridge Scholars Publishing.
- Link, B. G., Phelan, J. C., and P.Y Collins  
2004 Measuring Mental Illness Stigma. *Schizophrenia Bulletin* 30(3):511-541.
- Lucksted, A., and A. L. Drapalski  
2015 Self-stigma regarding mental illness: Definition, impact, and relationship to societal stigma. *Psychiatric Rehabilitation Journal* 38(2):99-102.
- Luhrmann, T. M.  
2000 *Of Two Minds: An Anthropologist Looks at American Psychiatry*. New York: Random House
- Lysaker, P. H., D. Roe, and P. T. Yanos  
2007 Toward understanding the insight paradox: internalized stigma moderates the association between insight and social functioning, hope, and self-esteem among people with schizophrenia spectrum disorders. *Schizophrenia Bulletin* 33(1):192-9.
- McGruder, J.H.  
2004 Madness in Zanzibar: An Exploration of Lived Experience. In *Schizophrenia, Culture & Subjectivity*. J. Jenkins and R. Barret, eds. Cambridge: Cambridge University Press.
- Miller, G.  
2014 Is the agenda for global mental health a form of cultural imperialism? *Med Humanit* 40(2):131-4.
- Mishra, V.  
2014 The Return of the Native: Reflections on the new order in Fiji. *Landfall* 227:87-100.
- Naidu, V., Driver, M., Tuisawau, S., Rouse, P., Urai, D., and G. Goundar

- 2005 Violence in Fiji: Presentations from a Panel Discussion on Violence in Fiji Held on 28 August 2004 at the Cathy Hotel, Lautoka, *Fijian Studies: A Journal of Contemporary Fiji*, 3(1):159-167.
- Nastasi, B. K., Schensul, J. J., Schensul, S.L., Mekki-Berrada, A., Pelto, P. J., Maitra, S., Verma, R. and N.Saggurti
- 2015 A model for translating ethnography and theory into culturally constructed clinical practices. *Culture, Medicine and Psychiatry* 39(1):92-120.
- Nichter, M.
- 2010 Idioms of Distress Revisited,. *Culture, Medicine and Psychiatry* 34(401-416).
- O'Neill, T.D.
- 1997 Psychiatric Anthropology and Psychiatry. *Anthropology Newsletter* 17.
- Orley, J.H.
- 1970 *Culture and Mental Illness: A Study of Uganda*. Nairobi: East African Publishing House.
- Patel, V., and M. Prince
- 2010 Global Mental Health. *The Journal of the American Medical Association* 303(19):1976-1977.
- Pescosolido, B. A., Martin, J. K., Lang, A., and S. Olafsdottir
- 2008 Rethinking theoretical approaches to stigma: a Framework Integrating Normative Influences on Stigma (FINIS). *Social Science and Medicine* 67(3):431-40.
- Price, J., and I. Karim
- 1978 Matiruku, a Fijian madness: an initial assessment. *The British Journal of Psychiatry* 133(3):228-230.
- Ram, K.
- 2015 Moods and Method: Heidegger and Merleau-Ponty on Emotion and Understanding in *Phenomenology in Anthropology: A Sense of Perspective*, Ram, K and C. Houston, eds., Indiana University Press
- Reavley, N. J., and A. F. Jorm
- 2011 Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma. *Australian New Zealand Journal of Psychiatry* 45(12):1086-93.
- Ritsher, J. B., and J. C. Phelan
- 2004 Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research* 129(3):257-65.
- Roberts, G.
- 2007 Masculinity, Mental Health and Violence in Papua New Guinea, Vanuata, Fiji and Kiribati. *Health Promotion International* 14(2):35-41.
- Roberts, G., M. Cruz, and E.S. Puamau
- 2007 A proposed future for the care, treatment and rehabilitation of mentally ill people in Fiji. *Health Promotion International* 14(2):107-110.
- Schensul, J. J.
- 1999 Focused Group Interviews in *Enhanced Ethnographic Methods: Audiovisual Techniques, Focused Group Interviews and Elicitation Techniques*. J.J. Schensul, M.D. LeCompte, B.K. Nastasi, and S. Borgatti, eds. Pp. 51-114. UK: Altamira Press.
- Scheper-Hughes, N.
- 2001 *Saints, Scholars & Schizophrenics: Mental Illness in Rural Ireland*. Berkley University of California Press.

- Schwartz, L.R.  
1969 The Hierarchy of Resort in Curative Practices: The Admiralty Islands, Melanesia. *Journal of Health and Social Behavior* 10(3):201-209.
- Sivakumaran, H., George, K., Naker, G. and K. Nadanachandran  
2015 Experience from mental health clinics held during medical service camps in Fiji. *Australasian Psychiatry* 23(6): 667-9,
- Summerfield, D.  
2012 Afterword: against "global mental health". *Transcultural Psychiatry* 49(3-4):519-30.
- Taket, A., Crisp, B.R. Nevill, A., Lamaro, G., Graham, M. and S. Barter-Godfrey  
2009 Introducing theories of social exclusion and social connectedness. In *Theorising Social Exclusion*. A. Taket, B. Crisp, A. Nevill, G. Lamaro, M. Graham, and S. Barter-Godfrey, eds. Pp. 1-34. Oxon: Routledge.
- The World Bank  
2013 *Population Data: Fiji*, Vol. 2014. Washington: The World Bank.
- Thirthalli, J., and C. N. Kumar  
2012 Stigma and disability in schizophrenia: developing countries' perspective. *International Review of Psychiatry* 24(5):423-40.
- Tomlinson, M.  
2004 Ritual, Risk, and Danger: Chain Prayers in Fiji, *American Anthropologist*, 106(1):6-16.
- 2007 Mana in Christian Fiji: The Interconversion of Intelligibility and Palpability. *75(3):524-553*.
- 2014 Bringing Kierkegaard into anthropology: Repetition, absurdity, and curses in Fiji. *American Ethnologist* 41(1):163-175.
- Vogel, D.L., Bitman, R.L and Wade, J.H. and N.G. Hammer  
2013 Is Stigma Internalized? The Longitudinal Impact of Public Stigma on Self Stigma. *Journal of Counseling Psychology* 60(2):311-316.
- Waldram, J.B.  
2000 The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues. *Medical Anthropology Quarterly* 14(4):603-625.
- Watters, E.  
2010 *Crazy Like Us: The Globalisation of the American Psyche*. New York: Free Press.
- Waxler, N.E.  
1977 Is Mental Illness Cured in Traditional Societies? A Theoretical Analysis. *Culture, Medicine & Psychiatry* 1(3):233-253.
- WHO  
2008 *mhGAP: Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders*. World Health Organisation.
- 2010 *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Program (mhGAP)*. World Health Organisation
- Wiley, A.S., and J.S. Allen

2008 Anthropological Perspectives on Health and Disease In, A.S Wiley and J.S Allen *Medical Anthropology: A Biocultural Perspective*, pp. 11-35. UK Oxford University Press

Wolf, M.

1992 *A Thrice Told Tale*. California: Stanford University Press.

Yang, L., Kleinman, A., Link, B.G., Phelan, J.C., Lee, S and B. Good

2007 Culture and stigma: adding moral experience to stigma theory. *Social Science & Medicine* 64(7):1524-35.

## APPENDIX 1: ETHICAL APPROVAL



**Office of the Deputy Vice-Chancellor (Research)**  
Research Office  
C5C Research HUB East, Level 3, Room 324  
MACQUARIE UNIVERSITY NSW 2109 AUSTRALIA  
**Phone** +61 (0)2 9850 7850  
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**Email** ethics.secretariat@mq.edu.au

26 November 2014

Dr Eve Vincent  
Department of Anthropology  
Faculty of Arts  
Macquarie University  
NSW 2109

Dear Dr Vincent

**Reference No:** 5201400985

**Title:** Mental Illness in Fiji: An Ethnographic Study on How Social Attitudes and Individual Understanding Shape the Help-Seeking Behaviour of the Mentally Ill and their Carers

Thank you for submitting the above application for ethical and scientific review. Your application was considered by the Macquarie University Human Research Ethics Committee (HREC (Human Sciences & Humanities)) at its meeting on 24 October 2014 at which further information was requested to be reviewed by the Ethics Secretariat.

The requested information was received with correspondence on 17 November 2014.

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted at:

- Macquarie University

This research meets the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2007 – Updated March 2014) (the *National Statement*).

**Details of this approval are as follows:**

**Approval Date:** 26 November 2014

The following documentation has been reviewed and approved by the HREC (Human Sciences & Humanities):

Documents reviewed	Version no.	Date
Macquarie University Ethics Application Form & Appendix B: Research to be Undertaken Outside Australia	2.3	July 2013
Correspondence from Dr Vincent & Ms McDonald responding to the issues raised by the HREC (Human Sciences and Humanities)		Received 17/11/2014
MQ Participant Information and Consent Form (PICF)	1	14/11/2014

Focus Group Questions	1	25/09/2014
Interview Questions	1	25/09/2014

This letter constitutes ethical and scientific approval only.

**Standard Conditions of Approval:**

1. Continuing compliance with the requirements of the *National Statement*, which is available at the following website:

<http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research>

2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.

3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.

4. Proposed changes to the protocol must be submitted to the Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email [ethics.secretariat@mq.edu.au](mailto:ethics.secretariat@mq.edu.au)

The HREC (Human Sciences and Humanities) Terms of Reference and Standard Operating Procedures are available from the Research Office website at:

[http://www.research.mq.edu.au/for/researchers/how\\_to\\_obtain\\_ethics\\_approval/human\\_research\\_ethics](http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics)

The HREC (Human Sciences and Humanities) wishes you every success in your research.

Yours sincerely



**Dr Karolyn White**

Director, Research Ethics & Integrity,

Chair, Human Research Ethics Committee (Human Sciences and Humanities)

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.

## Fiji National Research Ethics Review Committee

Phone: (679) 3306177 / 3221 424

Fax : (679) 3318227

Ministry of Health  
P.O. Box 2223, Govt. Bldgs.  
Suva, Fiji Islands  
Email : [mere.delai@govnet.gov.fj](mailto:mere.delai@govnet.gov.fj)

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5<sup>th</sup> February 2015

Ms. Natasha Nafiza McDonald  
Macquarie University  
**Australia**

Dear Natasha,

**Title:** Mental Illness in Fiji: An Ethnographic Study on How Social  
Attitudes and Individual Understanding Shape the Help-Seeking  
Behaviour of the Mentally Ill and their Carers

**FNRERC Reference Number:** 2014.123.C.D

**Principal Investigator:** Natasha N McDonald, Australia

**Co-Investigator(s):** Dr.Ordile Chang – FNU,Fiji

I am pleased to advise you that the FNRERC has granted Ethical and Technical approval  
for your above-mentioned study.

Please note that the following conditions apply only and specifically to your approval.  
Failure to abide by these conditions may result in suspension or discontinuation of  
approval and /or disciplinary action.

- (a) **Variation to Project:** Any subsequent variations or modifications you might wish  
to make to your project must be notified formally to the Chair, Fiji National  
Research Ethic Review Committee for further considerations and approval. If the  
Chair considers that the proposed changes are significant, you may be required  
to submit a new application for approval of the revised project.
- (b) **Incidence or adverse effects:** Researchers must report immediately to the Chair  
of the FNRERC anything which might affect the ethical acceptance of the  
protocol including adverse effects on subjects or unforeseen events that might



affect continued ethical acceptability of the project. Failure to do so may result in suspension or cancellation of approval.

- (c) **Monitoring:** Projects are subject to monitoring at any time by the ethics Committee.
- (d) **Duration of Approval:** approval is till the duration of project as outlined in the research
- (e) **Progress/Final Report:** It is mandatory that the Principal Investigator provide a written report on the progress of the project and also upon completion of the project at the end of the year or at the conclusion of the project.

Please quote the FNRERC reference number and the name of the project in any future correspondence.

If you have any further queries on these matters, or require additional information, please do not hesitate to contact the secretariat on (+679) 3221 424 or e-mail: [mere.delai@govnet.gov.fj](mailto:mere.delai@govnet.gov.fj)

We wish you best of luck in your study.

Yours sincerely,



Sharon Biribo  
**Chairperson - FNRERC**

## APPENDIX 2: PARTICIPANT INFORMATION STATEMENT



ABN 90 952 801 237

Department of Anthropology  
Faculty of Arts

**Dr Eve Vincent**  
*Chief Investigator (Supervisor) Title*

Room 611  
Building W6A  
Macquarie University  
NSW 2109 AUSTRALIA  
Telephone: +61 2 9850 8026  
Email: [eve.vincent@mq.edu.au](mailto:eve.vincent@mq.edu.au)  
Website: <http://www.mq.edu.au>

**Mental Illness in Fiji: An Ethnographic Study on How Social Attitudes and Individual Understanding Shape the Help-Seeking Behaviour of the Mentally Ill and their Carers (Reference no. 5201400985)**

### PARTICIPANT INFORMATION STATEMENT

#### What is this study about?

You are invited to take part in a research study about how attitudes and understanding around mental illness in Fiji shape the way mentally ill individuals, their carers and families seek help, and the way they experience being mentally ill.

Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about. Participation in this research study is voluntary: it's your decision whether you wish to take part or not.

#### Who is conducting the study?

The study is being undertaken by Natasha McDonald a Masters of Research student (Anthropology) at Macquarie University, Sydney, Australia. This will take place under the supervision of Dr Eve Vincent at Macquarie University.

Dr Odille Chang is the local co-investigator for this research project. Dr Chang's role is to provide professional advice, local context and insight to this research project.

#### What will participation in the study involve for me?

I would like to observe your everyday life and daily activities. This study will be conducted over three sites: St Giles Psychiatric Hospital, Empower Pacific and the Psychiatric Survivors Association. I might

Mental Illness In Fiji  
V1. November 14, 2014

also ask you to participate in a one-hour-long interview and/or a Focus Group. Additionally, I may ask if you are willing to have your photo taken or a photo of your surroundings.

I am interested in your understandings, beliefs, attitudes and experiences around mental illness.

**Do I have to be in the study? Can I withdraw from the study once I've started?**

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at Macquarie University, St Giles Psychiatric Hospital, Psychiatric Survivors Association and Empower Pacific Fiji.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time.

You are also free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

If you take part in a focus group, you are free to stop participating at any stage or to refuse to answer any of the questions. However, it will not be possible to withdraw your individual comments from our records once the group has started, as it is a group discussion.

**Are there any risks or costs associated with being in the study?**

We will be discussing sensitive issues and you might experience feelings of distress or anger. All this research takes place in a supportive setting, with mental health professionals supervising. They will be on hand to provide support.

**Are there any benefits associated with being in the study?**

I hope you will contribute to research that will provide the broader community with insights into mental health in Fiji. Additionally, whilst they may not be any direct benefits, you will have the opportunity to share your experiences around mental health if you have not had the opportunity before.

**What will happen to information about me that is collected during the study?**

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published, but you will not be individually identifiable in these publications. Photos may also be used in published findings, however before they are used your consent will be sought.

Mental Illness in Fiji  
V1. November 14, 2014

**What if I would like further information about the study?**

When you have read this information, Natasha McDonald will be available to discuss it with you further and answer any questions you may have.

**What if I have a complaint or any concerns about the study?**

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the Macquarie University Human Research Ethics Committee (Reference no. 5201400985). As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect people who agree to take part in research studies.

If you have any complaints or reservations about any ethical aspects of your participation in this research you may contact the university using the details outlined below. Please quote the study title and protocol number.

Director, Research Ethics and Integrity, Human Research Ethics Committee, Macquarie University.

- Telephone: +61 2 9850 7854
- Email: [ethics@mq.edu.au](mailto:ethics@mq.edu.au).

Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

For local complaints please contact Mrs Mere Delai, Phone: 93424501; Email: [mere.delai@govnet.gov.fj](mailto:mere.delai@govnet.gov.fj)

*This information sheet is for you to keep*

## APPENDIX 2: PARTICIPANT CONSENT FORM



Department of Anthropology  
Faculty of Arts

**Dr Eve Vincent**  
*Chief Investigator (Supervisor) Title*

Room 611  
Building W6A  
Macquarie University  
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Telephone: +61 2 9850 8026  
Email: [eve.vincent@mq.edu.au](mailto:eve.vincent@mq.edu.au)  
Web: <http://www.mq.edu.au>

**Mental Illness in Fiji: An Ethnographic Study on How Social Attitudes and Individual Understanding Shape the Help-Seeking Behaviour of the Mentally Ill and their Carers**  
(REF: 5201400985)

### PARTICIPANT CONSENT FORM

I, .....[PRINT NAME], agree to take part in this research study, which is being conducted by Natasha McDonald as part of her Masters of Research degree.

In giving my consent I state that:

- ✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- ✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researcher.
- ✓ The researchers have answered any questions that I had about the study and I am happy with the answers.
- ✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at Macquarie University, St Giles Psychiatric Hospital, Psychiatric Survivors Association and/or Empower Pacific Fiji now or in the future.
- ✓ I understand that I can withdraw from the study at any time.
- ✓ I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don't wish to answer.

- ✓ I understand that I may leave the focus group at any time if I do not wish to continue. I also understand that it will not be possible to withdraw my comments once the group has started as it is a group discussion.
- ✓ I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.
- ✓ I understand that the results of this study may be published, and that these publications will not contain my name or any identifiable information about me.

I consent to:

- |   |     |                          |    |                          |
|---|-----|--------------------------|----|--------------------------|
| • <b>Audio-recording</b>                          | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| • <b>Photographs</b>                              | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| • <b>Archiving of study materials for 5 years</b> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| • <b>Being contacted about future studies</b>     | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| • <b>Reviewing transcripts</b>                    | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

**Would you like to receive feedback about the overall results of this study?**

YES ☐ NO ☐

If you answered **YES**, please indicate your preferred form of feedback and address:

☐ Postal: \_\_\_\_\_  
\_\_\_\_\_

☐ Email: \_\_\_\_\_

.....  
**Signature**

.....  
**PRINT name**

.....  
**Date**